Human Services in Illinois

A Point-In-Time Review of the Current System

Illinois Human Services Commission

June 2010

TABLE OF CONTENTS

June 2010

MESSAGE FROM THE CO-CHAIRS OF THE HUMAN SERVICES COMMISSION

On behalf of the Human Services Commission (commission), we are pleased to submit the first report to the Governor and members of the General Assembly.

The Executive Order creating the commission gives it this responsibility: "recommend measures to ensure the sustainability of high quality human service delivery in the State of Illinois and make recommendations for achieving a system that will provide for the efficient and effective delivery of high quality human services. The core components of this system to be determined by the commission and addressed in its recommendations shall include, but not be limited to, the following:

a. adequate appropriations for the provision of human services

b. process for determining fair, adequate and timely reimbursement

c. efficient management of publicly-funded programs and services

d. implementation of best practices within the human services field

e. outcome measures and accountability mechanisms

f. projections for future human services need based on demographic trends and other related variables"

Given the extensive scope of human services in our state, and in light of the commission's purpose as described in the Executive Order, the first report of the commission is designed to serve as a fact-based, "systematic review" and description of the human services system as it exists today. It is recognized that the current system is not at its optimal level. Funding for existing human services was reduced due to state budget limitations in FY 10. The reduction would have been even more significant if it had not been for support provided by federal stimulus funds, which are being used to cover costs for a number of critical services.

The commission has relied on the state agencies and the Governor's Office of Budget and Management for the budget data used in this report. State agencies were also instrumental in providing basic program information as described in the Methodology section. The report narrative is the collective work of commissioners, technical support team, state agencies, experts and stakeholders who contributed significantly to make sure that this report can serve as a helpful reference guide to understanding human services in Illinois.

We believe this report is unprecedented in its comprehensive coverage of most, if not all, human services managed by the eight state agencies covered under the Executive Order. The commission recognizes that there are human services managed by other state agencies which may not be included in this report. Additionally, the federal government provides human services funding to local government through formulas, such as the Community Development Block Grant; or to non-profit service providers through competitive funding processes, such as funding for homeless services. Many local governments and private philanthropy also support human services. These types of funding support are not included in this report. The report, therefore, covers most, but not all, human services programs and funding support.

Members of the commission contributed to the report through small working group sessions and comments provided through two rounds of draft report review. The draft report was also posted for public comments during the first two weeks of May, 2010. Finally, this report benefits from financial support provided by The Chicago Community Trust and the Donors Forum which allows for limited staffing needed to organize meetings and prepare the report. We wish to express our deep gratitude to all contributors to this report. The information it contains provides the foundation from which the commission will approach the next phase of work, where we will develop specific recommendations as outlined in the Human Services Commission Executive Order.

Respectfully submitted,

Toni Irving, Co-Chair
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INTRODUCTION

Governor Pat Quinn signed an Executive Order on November 22, 2009 that created the Illinois Human Services Commission. The commission's ultimate charge is to make recommendations that will "provide for the efficient and effective delivery of high quality human services". In order to accomplish this task, the first report of the commission is dedicated to building a shared understanding of the human services system: why it exists, who it serves, how it operates across the state, current funding levels and the critical issues, trends and challenges it faces.

This report is intended to be fact-based and to represent the collective view points of all the diverse sectors serving on the commission. It focuses on Illinois human services programs under the purview of the eight state agencies named in the Executive Order: the Department on Aging (DOA), Department of Children and Family Services (DCFS), Department of Corrections (DOC), Department of Healthcare and Family Services (DHFS), Department of Human Services (DHS), Department of Juvenile Justice (DJJ), Department of Public Health (DPH) and the State Board of Education (ISBE). Data on budgets and programs were provided by these state agencies. Narrative descriptions of the services were prepared and reviewed over a period of four months by private providers, state agencies, advocates and representatives of AFSCME Council 31 and SEIU Local 880.

Developing a common view on how best to describe the extensive range of services covered in this report has proven to be quite challenging. Some commissioners prefer to have program information presented as they are currently managed by the eight state agencies. Others prefer to organize program information by types of population served. Others want information organized by service area, to allow an examination across state agencies. Additionally, some commissioners want to show budgets for human services strictly by General Revenue Fund (GRF) allocations. Others wish to include GRF, other state funds as well as federal dollars to illustrate the complex financing of human services. There are clear merits and tradeoffs to each one of these approaches. Given the commission's duty to produce a report, this document represents the best work possible under time and staff resource constraints and the desire to accommodate the various approaches to the extent possible, with the available information

The report contains the following sections:

1. Acknowledgements
2. Methodology
3. Overview of human services evolution and trends
4. Executive summary of FY 10 Illinois human service budget and programs
5. Detailed descriptions of services and programs
6. Appendices
7. Comments from commissioners

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This report represents the contributions and expertise of many individuals and organizations. The Human Services Commission gratefully recognizes the efforts of all who have provided content, commentary and guidance to this report.

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METHODOLOGY

This report was created through a multi-step process that utilized data and input from several sources. The review process was extensive and involved state agencies, commissioners and the public.

DATA COLLECTION FROM STATE AGENCIES

The Human Services Commission sought to develop a standardized set of data and information on the FY 10 human service programs managed by the eight agencies included in the Executive Order establishing the commission. In February 2010, these state agencies were asked to provide the following data for each of their programs:

- Name and purpose of the program
- Expected or desired key outcomes of the program
- Budget information for the program including: total FY 10 budget amount, federal funding for FY 10, general revenue funding (GRF) for FY 10, other funding sources for FY 10, and the percent funding change from FY 09
- Whether the program is required by federal law and/or required for maintenance of effort
- Whether the program is required by state law
- Whether the program is court mandated
- Total number of clients served
- Total number of Medicaid eligible and non-Medicaid eligible clients served, if applicable
- Whether the program services are delivered by the state, by nonprofit providers or by for-profit providers
- Annual amount of funding contracted to nonprofit and for-profit providers
- Whether the program serves children, adults, seniors or people with disabilities (or any combination thereof)
- Information on relevant best practices

In response to this request, the commission received data on nearly 600 programs from the eight state agencies.

Some variability likely exists in the way that each state agency completed the data questionnaire. Agencies may or may not have included administrative costs in their program budgets. In some instances agencies combined programs under a consolidated heading. It is possible that some federal contributions were not included. Therefore, the amounts reported to the commission may differ from budget figures published elsewhere by the agencies, including in the FY 10 Illinois Budget Book or the FY 10 Agency Budget Briefing provided by the Governor's Office of Management and Budget and the state agencies, respectively.

During the course of their program review, commissioners and members of the technical support team inquired about a small number of budget and program descriptions. After consultation with, and the approval of, agency staff, some data items in the original agency responses were amended for this

report. However, edits to agency data were few in number. Whatever minor discrepancies may exist between the various approaches used by state agencies to describe program budgets, the commission assumes that the budget and program data included in this report represent, in their totality, a reasonably accurate portrait of human services in Illinois.

Assigning Programs Information Provided by State Agencies to Categories

As noted above, the state agencies provided information on nearly 600 programs. From these, relevant programs were identified by screening out those that did not resemble human services, such as the general education programs of the State Board of Education, research programs of the Illinois Department of Public Health and purely administrative activities.

Three options were considered to organize the more than 300 programs that remained after the initial screening:

- By state agency (i.e. Department of Aging, Department of Corrections, etc.)
- By population served (i.e. children, adults, seniors, etc.)
- By service category (i.e. food and nutrition, housing, employment, etc.)

Based on the Executive Order's directive to use existing planning efforts and the fact that such work is well underway to coordinate public and private funding between state agencies, the City of Chicago, United Way, the Chicago Community Trust and Donors Forum, it was determined that the programs would be organized using "service categories" (codes) taken from the 211 Human Services Information and Referral Taxonomy. The 211 Taxonomy is used nationally to standardize classifications of human services across states, local communities, multiple funding sources and service providers.

Using the 211 Taxonomy, the program data provided by the state agencies was sorted into 12 service categories: Criminal Correctional System, Educational Support Services, Employment, Food and Nutrition, Health Care and Support, Housing and Shelter, Individual and Family Support, Mental Health, Public Assistance, Public Health, Rehabilitative/Habilitative Services and Substance Abuse Services.

Organizing data by service categories has allowed the commission to look at services across agencies and could potentially foster new ideas on how services could be provided more effectively. However, it is recognized that there are some challenges in using this approach to sort program data. Program managers and service providers need to be oriented to the new information framework. Also, some programs could be classified in multiple categories. Child care, for example, could be classified as public assistance, employment support or individual and family support. In instances where a program could be classified in multiple categories, a judgment call was made.

Additional Information Used In the Report

After reviewing the first draft, state agencies and commissioners sent reports and additional information about Illinois human service programs for possible inclusion in the report. Voices for Illinois Children, for example, provided extensive analysis on human services budget trends. Information from the Governor's Office of Management and Budget (GOMB), in Appendix D, highlights the amount of GRF resources made available for human services. These additional data are organized by state agency, not by service categories and not with the level of program detail found elsewhere in this report.

Role of the Technical Support Team and Report Editor

The commission is assisted by a volunteer technical support team consisting of Illinois-based leaders in the field of human services. These individuals represent a range of community organizations as well as universities. The Acknowledgements section of the report includes a list of technical support team names and affiliations.

The Technical Support Team compiled information on human service programs with the aid of the standardized data collection template, combined with their knowledge on the subject matter. The data and descriptions that they gathered provide the basis for much of this report's content.

The editor compiled separate reports prepared by the technical support team into comprehensive section drafts for each service category and incorporated comments received from the commissioners, state agencies and other reviewers.

Review Process

Commissioners, including staff at state agencies, provided input into the report at several points throughout this process. In early April, commissioners received sections of the draft report via email, and were asked to offer comments and clarifications via a response form. During the week of April 12, 2010, commission staff convened work groups around each of the 12 human services categories included in this report. At these sessions, commissioners had the opportunity to interact with the technical support team members who authored the report and to verbally communicate their assessment of the accuracy of the draft material. The technical support team and commission staff incorporated commissioner responses into subsequent report versions. Many commissioners were instrumental in the report preparation process and provided valuable resources. State agency staff also clarified details and offered program data, often within short time frames.

The first full draft report was presented to the full commission at its meeting on May 3rd. The draft report was also posted for public comment from May 3 – 16. Between May 3 rd to May 31st, a total of 68 sets of comments and revisions were submitted to the editor to be incorporated into the final draft which was approved by the commission at its June 8, 2010 meeting.

Commissioners were also provided with the opportunity to provide written comments to the report, to be included as needed in the final version due to the Governor and the Legislature on June 30, 2010.

OVERVIEW OF HUMAN SERVICES EVOLUTION AND TRENDS

Illinois's human services system is large and complex to meet the needs of a diverse state-wide population of nearly 13 million people. Designing a system that is responsive to residents living in rural communities and those in urban environments can be challenging. Furthermore, while most other states rely heavily on county governments to administer human services, Illinois maintains a state-run system with programs being delivered at the local level, supported by a mix of federal, state and local government funding as well as contributions from private foundations, corporations and individual donors. In addition, the nonprofit sector engages a large number of volunteers in the delivery of human services.

The wide range of human services available today has evolved over many decades. Early in our nation's history, when our population was smaller, neighbors helped one another in times of need. Later, waves of migration and population growth were met with formal, larger scale efforts, including settlement houses organized by private individuals, charitable organizations and churches. Up through the end of the 19th century, state-run programs and federal funding for them were the exception rather than the rule.

The Great Depression which began in 1929 and lasted until the late 1930s, forced many individuals into unemployment and poverty. At the height of the Great Depression, the unemployment rate was over 20 percent. Private charities were not equipped to meet the scale of needs of so many individuals and families during this period. It was for this reason that, in the early part of 20th century, government began to assume a greater role in charitable care, funding and providing services for human needs. The New Deal's centerpiece, the Social Security Act of 1935, created key safety net programs, including Old Age Assistance, Aid to the Blind, Aid to Dependent Children and Unemployment Insurance. Four years later, the Social Security Act was expanded to allow survivor benefits and, in 1950, to support people with disabilities.

As the list of milestones in Appendix F makes clear, human services were often developed one program at a time, in a piecemeal fashion to address changing needs over time. Recently passed health care reform legislation represents the latest public policy in the evolution of human services.

Each human service program was created out of the recognition of a specific need and resolution, reached by the majority of those elected to serve the collective interests of our society. Each has been refined and changed over the years as needed, to respond to changing needs, funding and best practices. Some were created at the federal level, others at the state level. Those we have today represent the latest set of public policies on how to meet multiple needs that require either short-term or long-term solutions.

Fundamentally, the majority of human services programs are designed to alleviate poverty and provide assistance to vulnerable populations. The intent of most human service programs is to support Illinois residents to be as self-sufficient and productive as possible.

SPENDING TRENDS IN MAJOR HUMAN SERVICES AGENCIES

This information, developed by Voices for Illinois Children, covers spending trends in five core human service agencies: the Department of Healthcare and Family Services (DHFS), the Department of Human

Services (DHS), the Department of Children and Family Services (DCFS), the Department on Aging (DOA), and the Department of Public Health (DPH). The discussion does not include three state agencies represented on the Human Services Commission whose budgets only partly involve human services: the State Board of Education (ISBE), the Department of Corrections (DOC), and the Department of Juvenile Justice (DJJ).

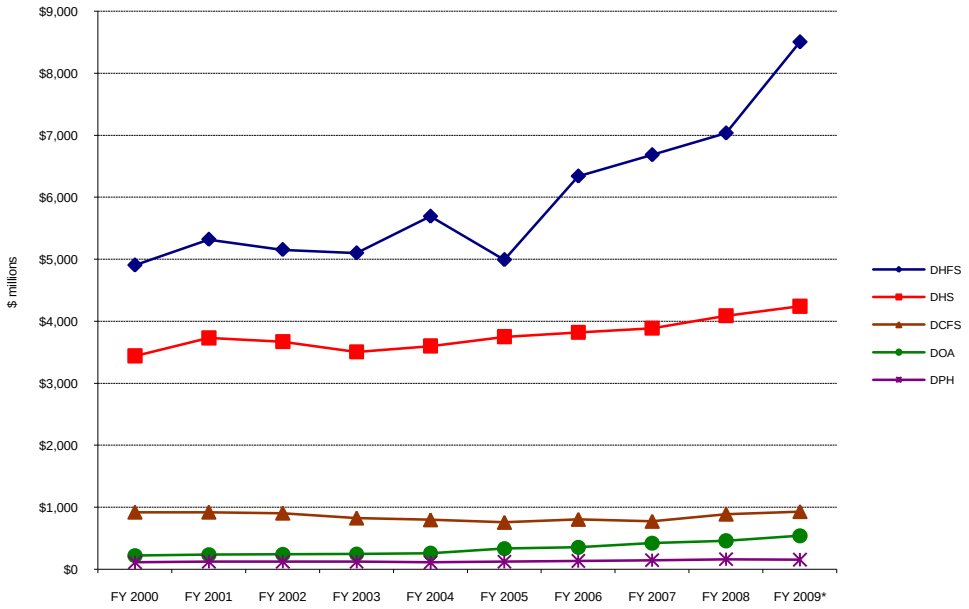
The text and related exhibits present expenditure data for both General Funds (GF) and All Appropriated Funds. GF, which include the General Revenue Fund (GRF), the Common School Fund, and the Education Assistance Fund, support the regular operating and program expenses of most state agencies. All Appropriated Funds include GF, special state funds, and federal trust funds.

Most GF spending involves state revenue sources, but about one-sixth is typically supported by federal revenue (primarily Medicaid matching funds). In some cases, "special state funds" are comprised of both state and federal revenue.

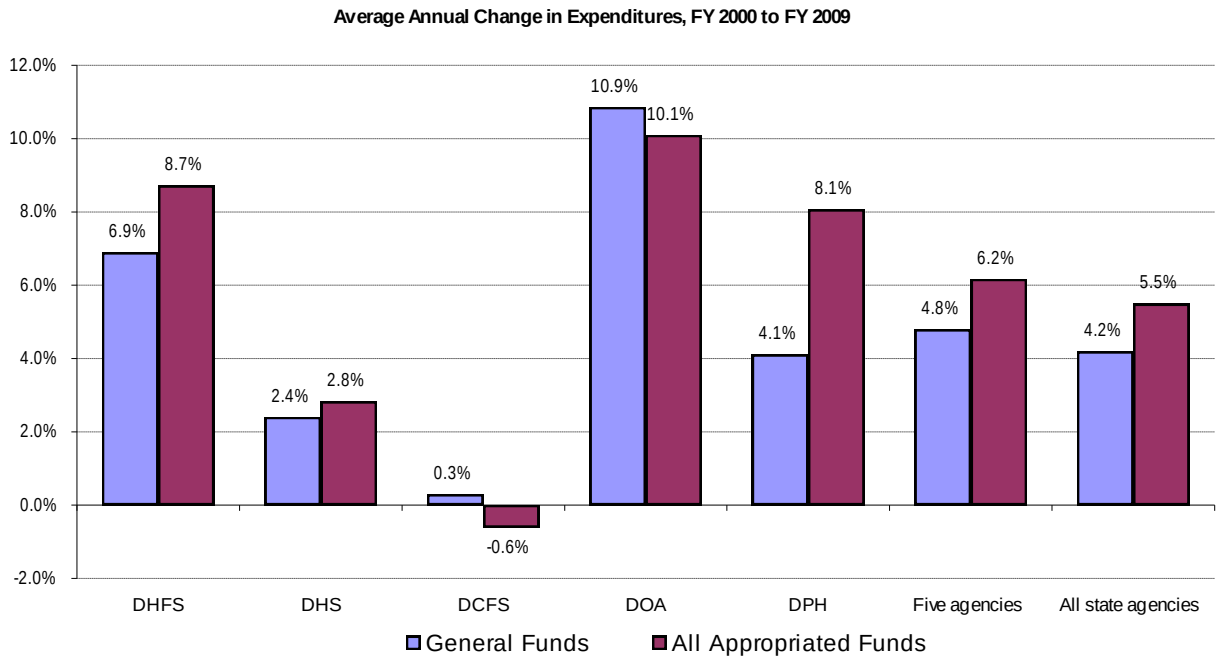
Between FY 00 and FY 09, GF expenditures by all state agencies increased at an average annual rate of 4.2 percent, which was the same as the growth of aggregate personal income in Illinois (4.2 percent) and only moderately higher than the rate of inflation (2.9 percent). Average spending growth from All Appropriated Funds was 5.5 percent.

Over the same period of time, expenditures by the five core human service agencies increased at an average annual rate of 4.8 percent for GF and 6.2 percent for All Appropriated Funds. There was wide variation across agencies, however. The rate of GF spending growth was 6.9 percent in DHFS and 10.9 percent in DOA but only 2.4 percent in DHS, 0.3 percent in DCFS, and 4.1 percent in DPH.

Core Human Service Agencies, General Funds Expenditures, FY 2000 to FY 2009
(in $ millions)



* Includes FY09 Budget Relief Fund.
Source: Budget & Tax Policy Initiative, Voices for Illinois Children; based on data from Illinois State Comptroller.



Source: Budget & Tax Policy Initiative, Voices for Illinois Children; based on data from Illinois State Comptroller.

Department of Healthcare and Family Services: Medicaid and related medical assistance programs constitute most of the DHFS budget.[1] GF spending in DHFS increased at average rate of 5.2 percent through FY 08 but jumped by 20.8 percent in FY 09. The FY 09 anomaly reflects the impact of enhanced federal Medicaid matching funds under the American Recovery and Reinvestment Act (ARRA). The Federal Medical Assistance Percentage (FMAP) for Illinois was raised from 50 percent to almost 62 percent. The requirements of ARRA also compelled the state to reduce its backlog of unpaid Medicaid bills, which stood at $2 billion at the end of FY 08. The original GF appropriation for DHFS in FY 09 was $7.0 billion, a small increase from the previous year. In response to ARRA, a supplemental appropriation brought FY 09 funding up to $8.6 billion. In the GF budget for FY 10, DHFS was funded at $6.8 billion.

Department of Human Services: In DHS, close to half of spending from All Appropriated Funds is supported by federal revenue. Federal support for GF spending includes Medicaid matching funds, the Temporary Assistance for Needy Families (TANF) block grant, the Child Care and Development Fund, the Social Services Block Grant, and funding for administration of the Food Stamp program (now Supplemental Nutrition Assistance Program). In the Division of Developmental Disabilities, the largest DHS program area, Medicaid covers more than 80 percent of expenditures.

[1] DHFS also has responsibility for child support enforcement. The expenditure data presented here exclude State Employee Group Insurance, which was shifted from the Department of Central Management Services to DHFS in FY 06.

From FY 00 to FY 09, average annual spending growth in DHS was 2.4 percent for GF and 2.8 percent for All Appropriated Funds — in both cases, lower than the rate of inflation (2.9 percent). The only major DHS program with steady and substantial GF spending growth during this period was the Home Services program for adults with physical disabilities, which increased at an average annual rate of 13.3 percent. About two-thirds of spending for this program is funded through Medicaid under a Home and Community-Based Services (HCBS) waiver. Aside from Home Services, GF spending in DHS grew at an average annual rate of less than one percent from FY 00 to FY 09.

Department of Children and Family Services: GF spending in DCFS declined by 3.8 percent per year between FY 00 and FY 05 but then increased at an average rate of 5.6 percent over the next four years. Nonetheless, GF expenditures in FY 09 were only slightly higher than they had been in FY 00. DCFS spending from All Appropriated Funds was 5.5 percent lower in FY 09 than at the beginning of the decade. Nearly half of total DCFS spending is covered by federal grants, including Title IV-E funding for foster care and adoption assistance, part of the TANF block grant, and some Medicaid funding.

Department on Aging: From FY 00 to FY 09, DOA expenditures increased at an average annual rate of 10.9 percent for GF and 10.1 percent for All Appropriated Funds. Most of the growth involved the Community Care Program, which represented 65 percent of DOA's GF budget in FY 09 and 84 percent in FY 10. More than half of CCP spending is funded through a Medicaid HCBS waiver. About one-fourth of DOA spending is from All Appropriated Funds supported by federal revenue.

Department of Public Health: In DPH, GF expenditures have fluctuated considerably — jumping 11 percent in FY 01 but declining in each of the next three years. DPH spending then increased at annual rate of 9.9 percent over four years before dropping by 3.9 percent in FY 09. Federal funds typically account for about 40 percent of DPH spending from All Appropriated Funds

Conclusion on Spending Trends: Since FY 00, overall spending trends in human services agencies have been largely driven by Medicaid — not only in DHFS but also in DHS and DOA. Excluding DHFS, average annual growth rates for the core human service agencies were only 2.6 percent from the GF and 2.7 percent from All Appropriated Funds. If DHS Home Services and DOA Community Care were also excluded, the GF spending growth rate would drop to 1.6 percent.

The five core human service agencies accounted for 33 percent of spending from All Appropriated Funds in FY 00 and 34 percent in FY 08.[2] Over this same period, the share for DHFS increased from 17 percent to 22 percent. Shares for DHS and DCFS declined, while shares for DOA and DPH grew but remained quite small. Aside from DHFS, human services spending as a proportion of the state budget has changed very little in the past decade. Refer to Appendix C for more details.

CURRENT CHALLENGES AND FUTURE TRENDS

The current economic recession and the resulting state budget shortfalls require the state to make difficult choices. In FY 10, services required by federal and state laws are protected, while other services were reduced or eliminated. Increasingly, the human services system is challenged by questions of

[2] FY 09 is excluded from the analysis because of the temporary effects of federal ARRA funds, especially for DHFS.

funding support, goals, priorities and results. Contracted providers report that chronic payment delays mean they serve, in effect, as the state's "bank," which puts both their fiscal stability and ability to provide services at risk. Resolutions to these questions must address a number of different views on values of different human services and problem solving strategies, as well as challenges that cut across the system, including these:

- *Contrary viewpoints on how to best deliver particular types of human services:* How to best meet the needs of people with disabilities and seniors – whether in an institution or community setting – is a key question in the human services field. While the answer is a matter of selecting the service approach that is cost efficient and able to achieve the best results for the consumers, this question is sometimes framed as a choice between who provides services: state employees or community based providers. As this report makes clear, the Illinois human services system needs both state employees and community service providers in their most effective and appropriate roles.

- *More cost-efficient and cost-effective access to public benefits:* Most of the state's Information Technology (IT) systems that support access to services – from intake and assessment to case management to interaction with contracted providers – are 25 to 30 years old. Many were designed to support a single program, and have a limited ability to share data. As noted in several places in this report, the practical effect of this is that people often must repeat entire application processes each time they request a specific program or service. Where systems cannot exchange data, the state's ability to evaluate the effectiveness of programs is also limited.

  Working with redundant, hard-to-integrate processes is a significant drain on service customers, time and resources. Growth in number of individuals and families needing public benefits coupled with reductions in the state workforce mean that state employees have to manage large caseloads with outdated, program-centric IT systems. The work of creating an integrated IT system or systems that will expand access to services, improve the quality and appropriateness of the services provided and streamline processes so that the system operates in an efficient manner requires us to recognize that the system must invest in itself in order to better serve others.

- *The question of when and where to consolidate and when and where to specialize:* Many of Illinois's current human services programs managed by the Illinois Department of Human Services at one time were housed under six different state agencies. The 1997 reorganization of DHS and, most recently, legislation introduced by Governor Quinn to merge DJJ into DCFS, signal support for consolidations. Going forward, we will want to look at the results of past consolidation efforts, and ask where and how service coordination and consolidation that bring economic benefits and positive results for human services clients.

- *The benefits and consequences of maximizing Medicaid dollars:* Increasingly the state has restructured its funding approach and service eligibility determination processes to increase the share of federal support for human services through the Medicaid match, where the federal government pays approximately half of all costs. This has enabled the state to provide services to many residents.

However, some services are limited to those who are Medicaid eligible and restricted to what can be reimbursed by the Medicaid federal match, and there have been insufficient dollars available to fund non-matchable services. Because of this, community service providers are less able to serve non-Medicaid eligible clients. Many wrap-around services, which are not Medicaid reimbursable, are no longer provided. The "Medicaidization" of human services has restructured contract agreements between the state and community service providers from annual grants to fee-for-service arrangements. This new contractual arrangement limits services to Medicaid-eligible clients and causes payment delays since grant funding is different than Medicaid billings.

Thanks to federal stimulus funds, Medicaid has been protected from cuts by "maintenance of effort" requirements. This is a good thing, but Medicaid requires a state funding match, which reduces availability of state funds for other programs. And as noted throughout this report, many services that were supported by stimulus funds now face uncertainty when these funds run out.

- *Uneven treatment of human services providers:* While unionized state employees can periodically negotiate salary increases and benefits through their contracts, many nonprofit service providers have not received cost-of-living increases for years. When the state experiences cash flow problems, which has become the norm rather than the exception, state employees continue to receive a salary – as they should – while payments to nonprofit contractors are delayed. Many nonprofit providers have had to secure loans to pay their employees and so incur further costs, because of the interest on these loans. The state's inability to make payments on time has created financial stress for many service providers and could result in the closure of programs. The Donors Forum's *Fair and Accountable: Partnership Principles for a Sustainable Human Services System* report reflects an effort underway to find solutions to this problem.[3]

- *The need to avoid unintended consequences:* While human services in Illinois are provided through a vast array of agencies and programs, the issues that human services address and their impact are interconnected. For example, if services in one part of the system are reduced, it may increase demand for services in other parts of the system. Conversely, investing in some service areas can create cost savings in others. For example, investment in public health programs that reduce the spread of disease and in food and nutrition programs that give people access to healthy foods can save money in future medical costs. It is important to keep in mind that no program or agency operates in a vacuum.

- *The needs to address shifting demographics and age-related transitions:* The state population has changed over time due to immigration and higher birth rates among immigrants, particularly among Asians and Latinos.[4] The changing demographics among state residents raise the question of how well service delivery systems and funding allocations reflect these changes. As noted in several places in this report, the same question exists for age-related transitions that all populations experience. For example, parents and children lose eligibility for many services,

[3] Donors Forum (2010). *Fair and Accountable: Partnership Principles for a Sustainable Human Services System.* Available at http://www.donorsforum.org/s_donorsforum/bin.asp?CID=14836&DID=33993&DOC=FILE.PDF

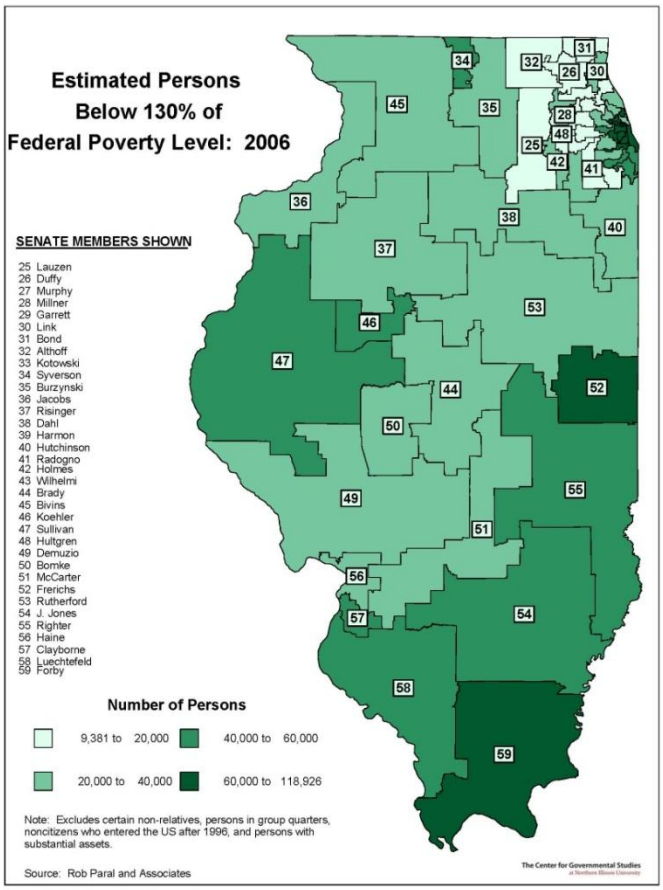
[4] For example, nearly 74 percent of the Latino population growth between 2000 and 2008 has occurred due to births rather than immigration. In 2008, Latinos accounted for 15.3 percent of Illinois' population.

usually when a child reaches the age 19. Fewer resources for human services will challenge the need to balance provision of services to current consumers and others needing access to the same services.

- *Finite and shrinking resources in the context of increasing needs:* According to a recent report issued by the Civic Federation, Illinois entered the current recession with a "structural deficit" (where expenditures regularly exceed revenue) that has only worsened under the poor economy.[5] As of this writing, the state's expected deficit for the FY 11 budget is $12.8 billion. This budget crisis takes place at the same time that economic trends indicate that there will be more demands for human services, as shown in the charts, tables and discussion below.

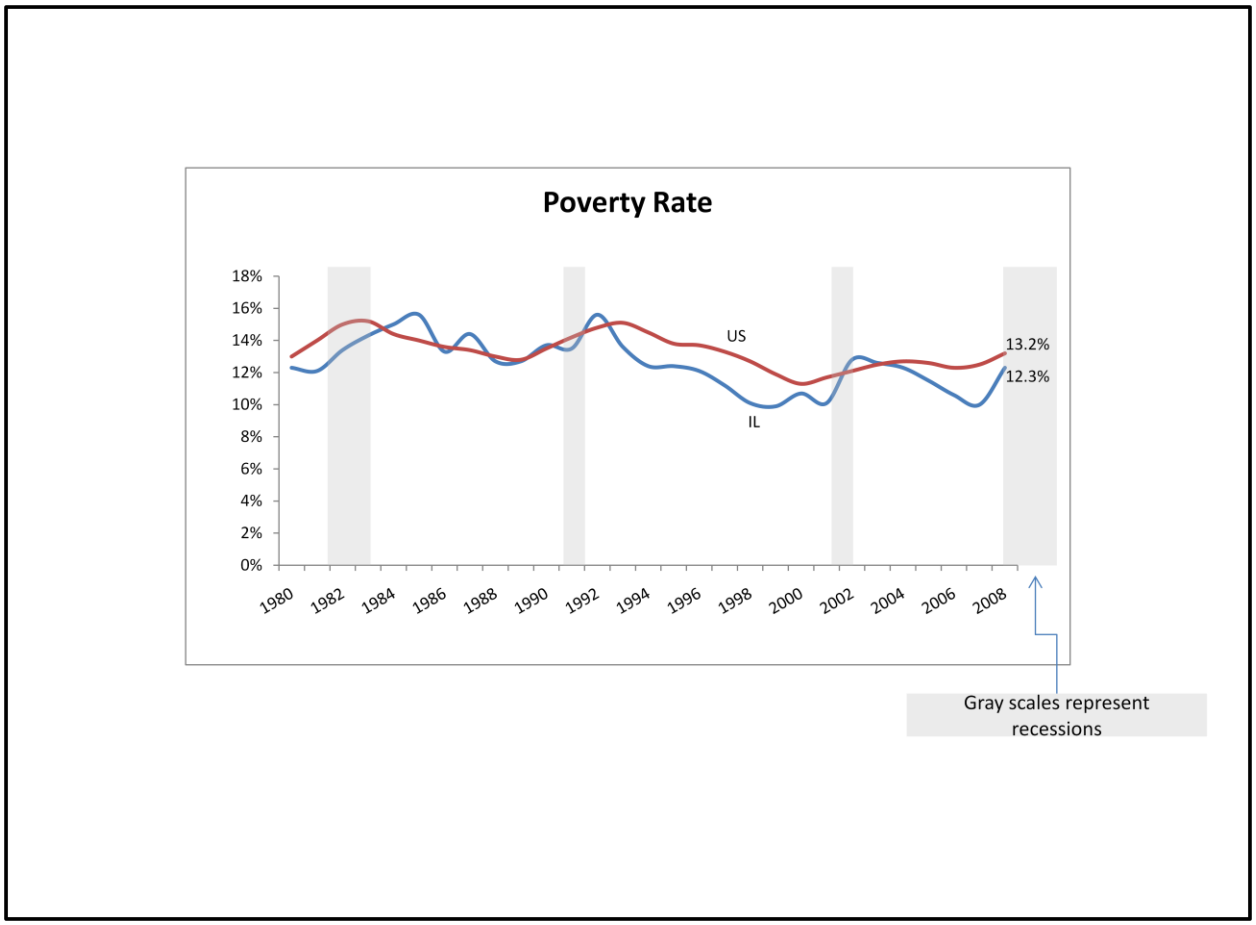
DEMOGRAPHIC TRENDS AFFECTING HUMAN SERVICES

Many human service programs have eligibility requirements tied to the federal poverty level (FPL). As the following map makes clear, need-based eligibility for human services is not limited to any one area of Illinois.



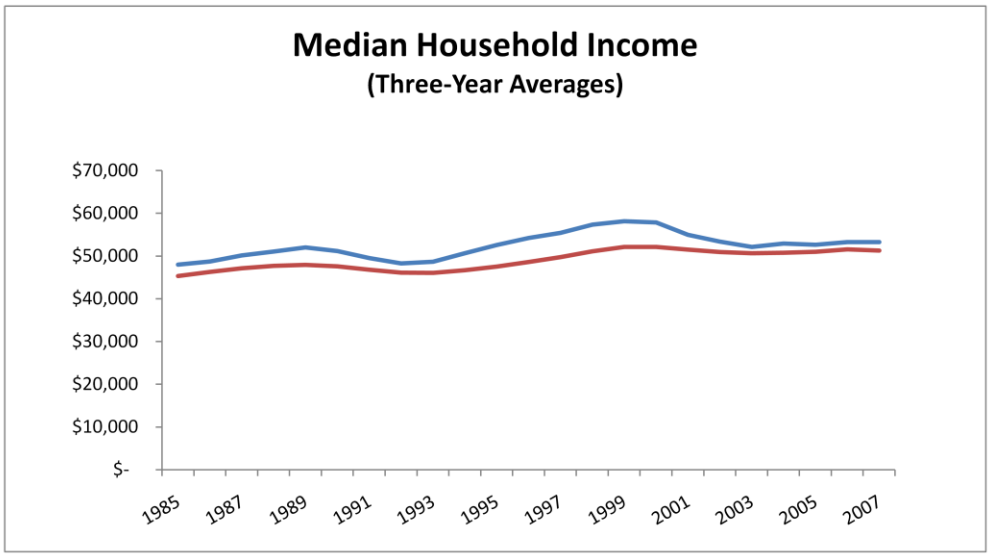
[5] *A Fiscal Rehabilitation Plan for the State of Illinois*, (Chicago, IL: The Civic Federation), February, 2010, page 6.

The next series of charts cover trends that will affect the need for human services in the years ahead. The first outlines many past stretches where Illinois has had a lower poverty rate than the US overall, including today. However, it also shows that our state's poverty rate historically has spiked higher than the nation as a whole in the wake of recessions; a recurring trend that we may soon confront once more. In fact, as the 2008 data points indicate, it appears that Illinois may be again heading in the higher-than-the-US-overall direction, post recession.



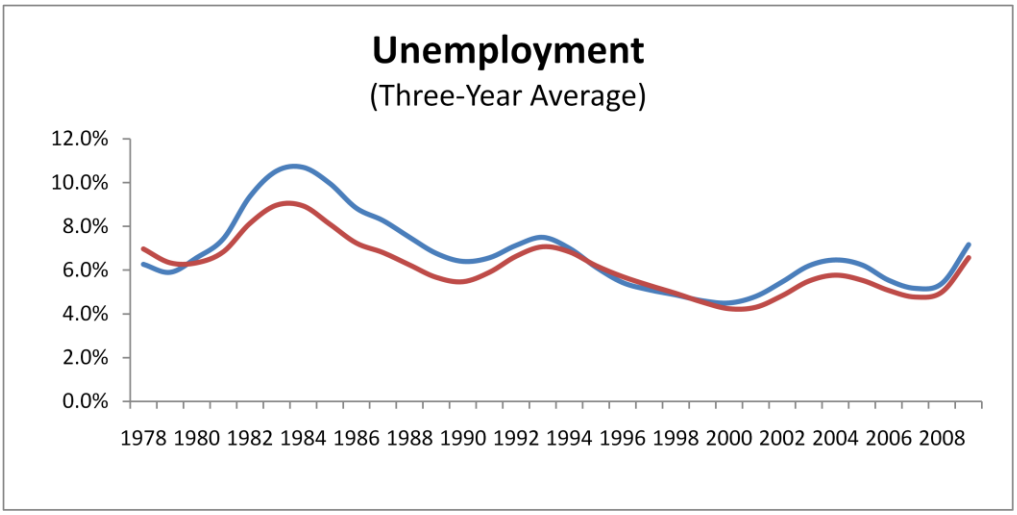
The trend data on median household income, below, is adjusted for inflation. Illinois, like much of the Midwest, is in trending downward, which pressures government-funded human services programs in terms of both resources and demand: when incomes are down or flat, there is less tax revenue coming in, and people have less money to spend on what they need.

Illinois household incomes are down from late 1990s peak

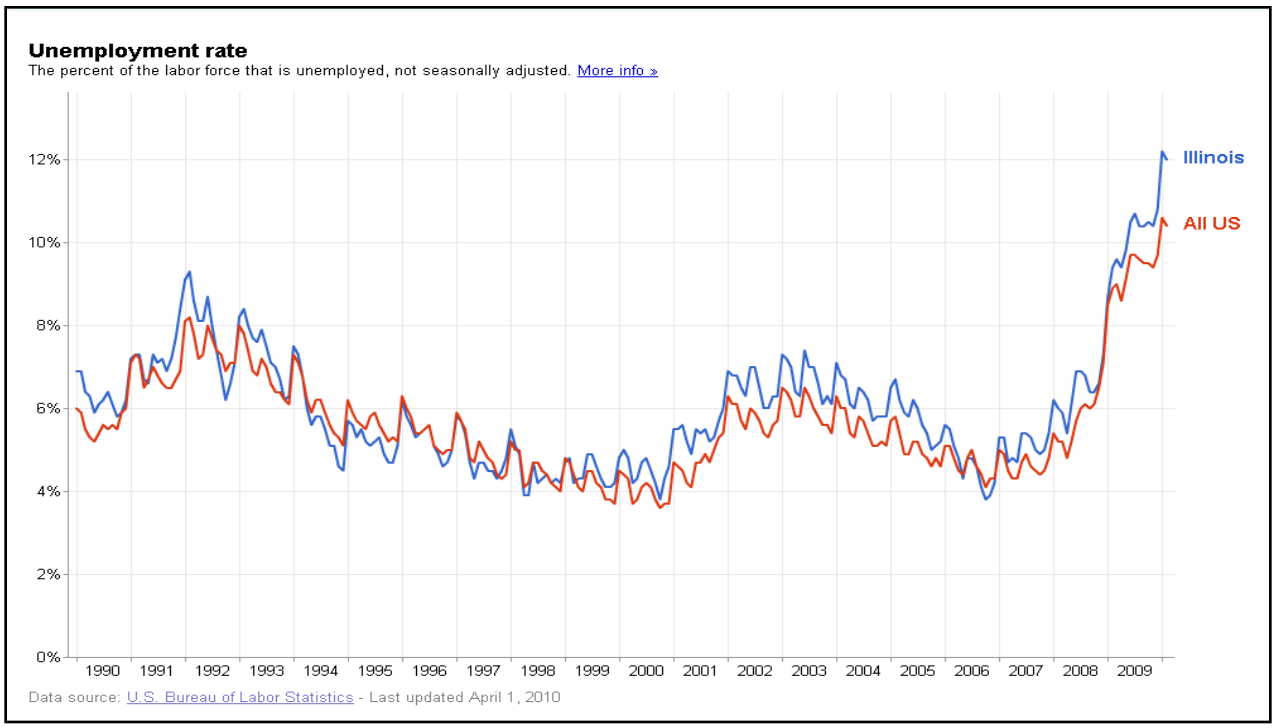


Amounts are in inflation-adjusted dollars

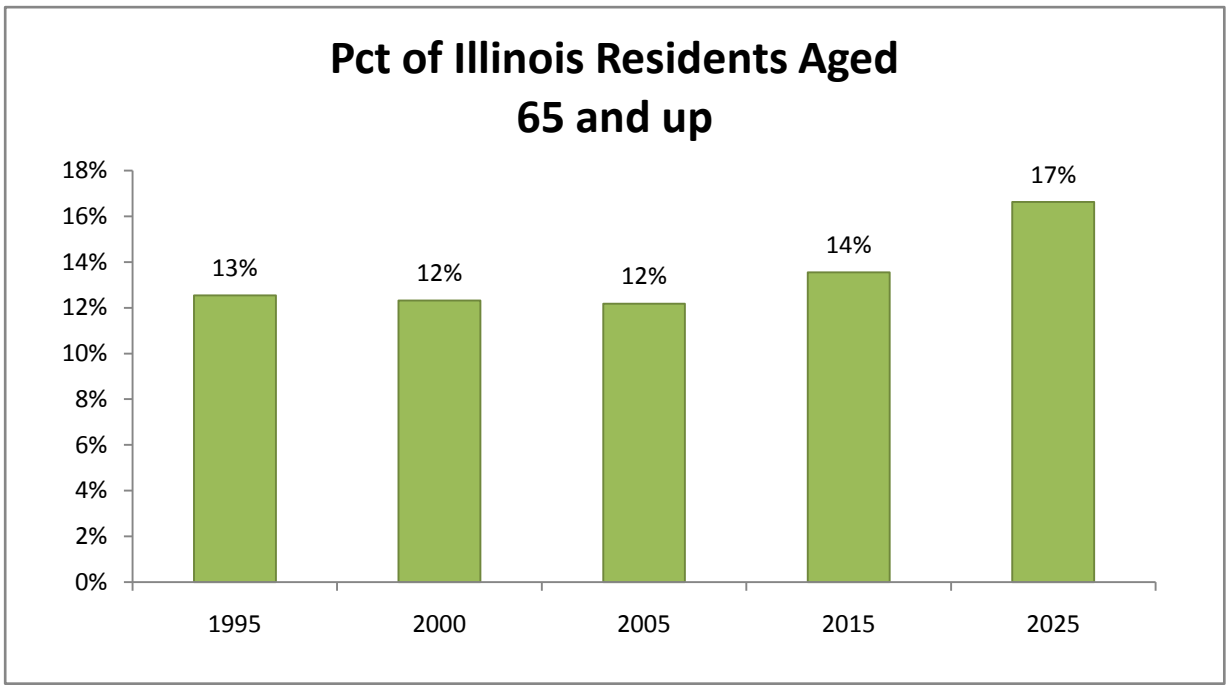
Unemployment rate highest in a decade



Illinois' unemployment rate is higher than the national average.



The final chart shows a demographic trend that will significantly affect the need for human services: how our population is trending older, as the first wave of baby boomers reach retirement age.



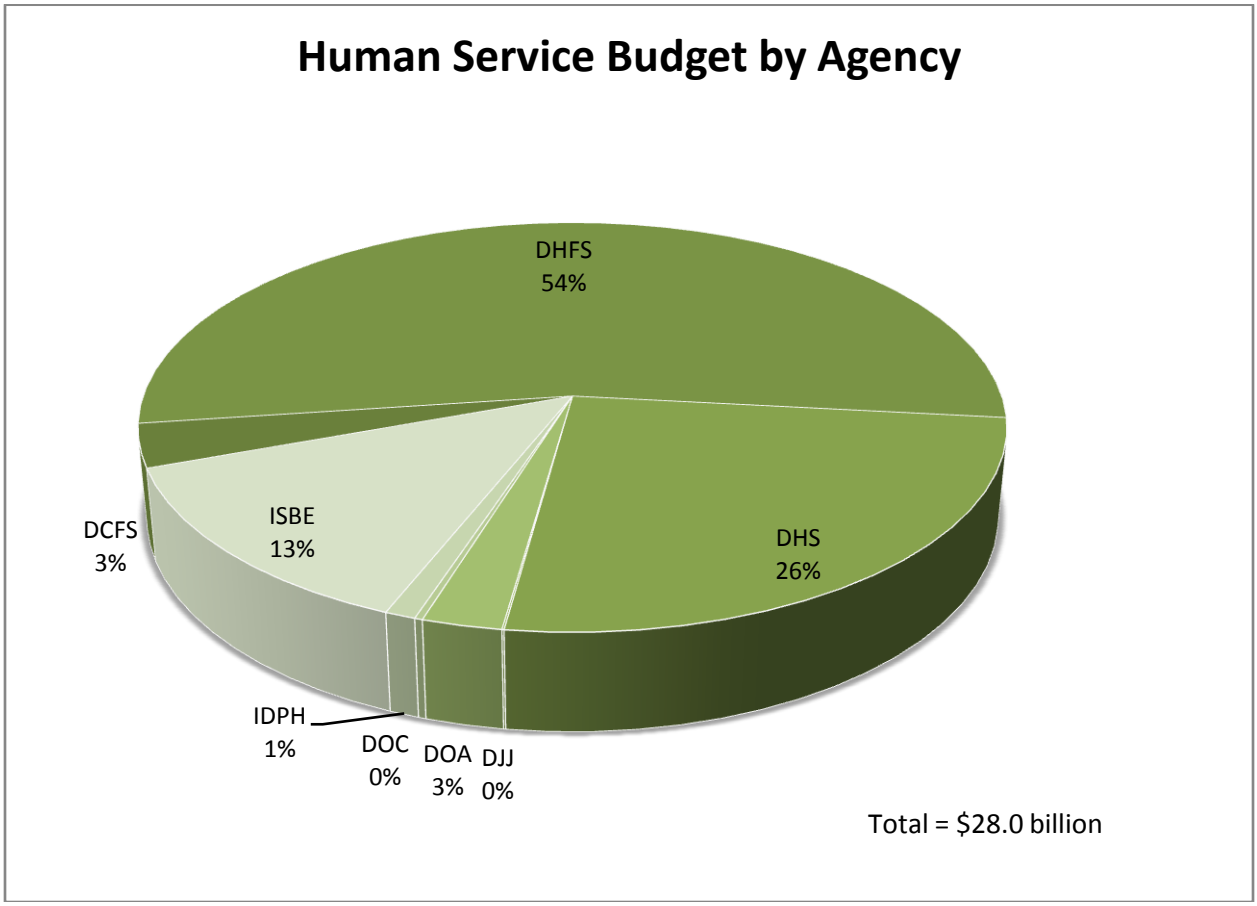
The senior population's growing need for healthcare and its eligibility for Medicare services that provide it are likely to pressure resources for other types of services and other populations.

Additionally, as noted above, there is dramatic change in the demographic makeup of the Illinois population, with particularly notable growth in the Latino population. This changing demographic has implications on how services need to be designed to meet a statewide population that differs from previous decades.

EXECUTIVE SUMMARY OF FY 10 ILLINOIS HUMAN SERVICES PROGRAMS

Human service programs affect millions of Illinois residents and involve thousands of service providers. Data provided by state agencies represented on the Human Services Commission show that the system is financed by a mix of federal and state funding totaling approximately $27 billion and covering more than 300 services programs delivered or overseen by the following state agencies:[1]

Illinois Department on Aging (DOA)
Illinois Department of Children and Family Services (DCFS)
Illinois Department of Corrections (DOC)
Illinois Department of Healthcare and Family Services (DHFS)
Illinois Department of Human Services (DHS)
Illinois Department of Juvenile Justice (DJJ)
Illinois Department of Public Health (DPH)
Illinois State Board of Education (ISBE)



Of the more than 300 human service programs identified among the eight state agencies, some serve broad cross-sections of lower-income persons, while others are highly specialized and meet specific, narrowly defined

[1] The Department of Commerce and Economic Opportunity was not part of the Executive Order. Since this agency oversees a number of employment programs that are key to the human services system, a separate summary of them is provided in Appendix E.

needs. The actual services include a wide array of activities: counseling, cash assistance, nutrition support, healthcare, public education and other supportive services. These services are delivered by thousands of providers, including state employees and professionals in the non-profit and for-profit sectors.

For this report, Illinois human services are grouped, using the 211 Taxonomy,[2] into 12 service categories, listed in the chart below, that correspond to the 12 sections that form the main body of this report. This approach has allowed for a review of the system that cuts across agency jurisdictions and traditional funding silos. Like any classification system, it has benefits and limitations. To help the reader, the table below summarizes where the eight state agencies represented on the commission appear within the 12 service areas that the 211 Taxonomy produced.[3]

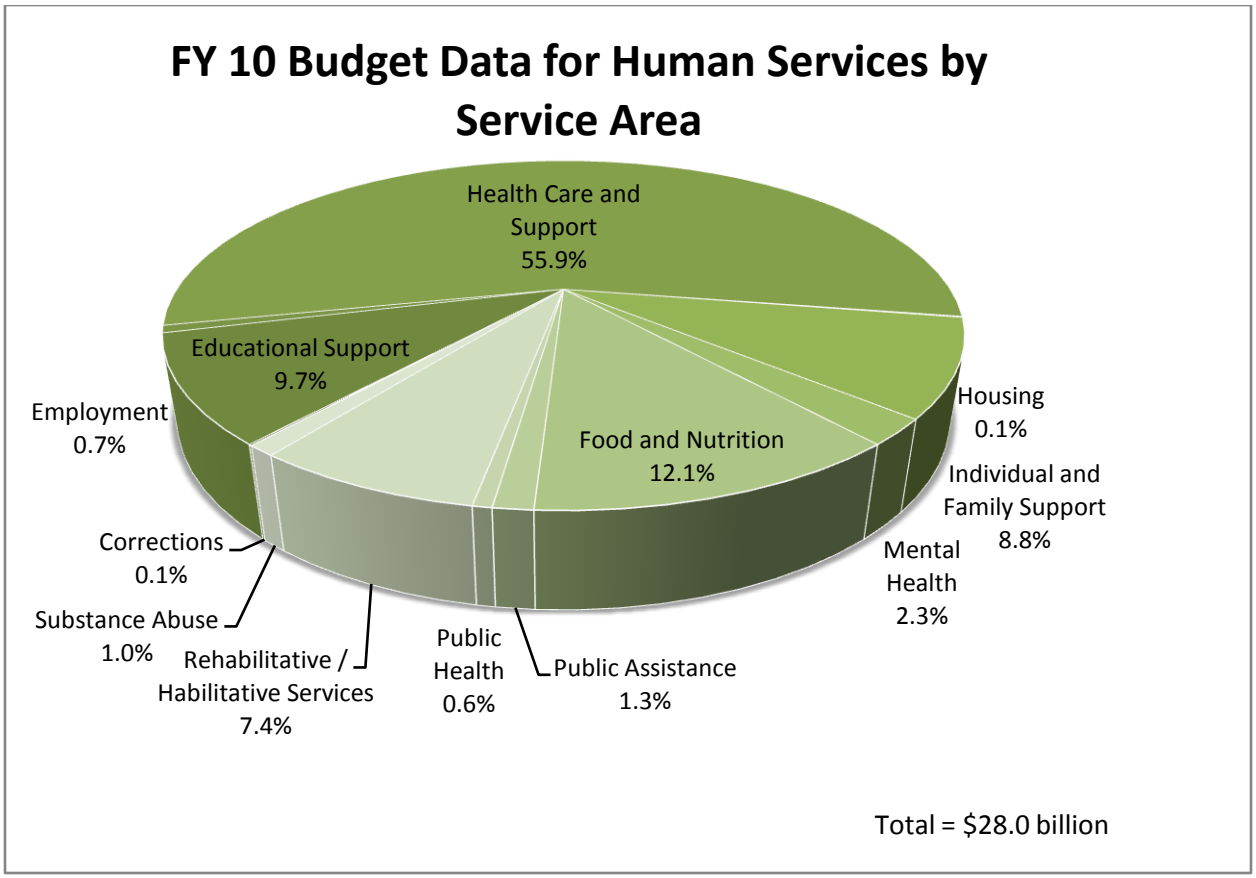
Human Service Categories: Sorted by Agency and Report Section Title[4]

REPORT SECTION TITLE	DCFS	DHFS	DHS	DJJ	DOA	DOC	IDPH	ISBE
Criminal Correctional System	✓		✓	✓		✓		
Educational Support Services			✓	✓		✓		✓
Employment			✓		✓	✓		
Food and Nutrition			✓		✓			✓
Health Care and Support	✓	✓	✓		✓		✓	
Housing and Shelter			✓					
Individual and Family Support	✓		✓		✓	✓		✓
Mental Health			✓	✓		✓		
Public Assistance		✓	✓		✓			
Public Health							✓	
Rehabilitative/Habilitative Services			✓					
Substance Abuse			✓	✓		✓		

[2] The Executive Order that created the Human Services Commission directs the commission to use existing resources and planning efforts to support its work. This report therefore uses the 211 Taxonomy to organize the human services sector into a common set of categories. See the Methodology section for more information about the 211 Taxonomy.

[3] With over 300 programs to be categorized, judgment calls were made as necessary. For example, in order to produce a more comprehensive discussion under Health Care and Support, DHFS mental health programs are discussed there, rather than under "Mental Health." Cross references are used throughout the report to help the reader navigate a system that does not readily lend itself to bounded categories.

[4] This table is a guide to this report's structure and does not reflect interagency collaborations.



Human services are supported by a variety of funding sources. The specific funds used as a source of human services are a relevant issue because the state has varying levels of direct responsibility for resources contributed into each fund.

In this report, most budget figures represent the combination of state General Revenue Fund (GRF) federal funds and other special funds. For specific information on how much GRF is allocated to which human service agencies and programs please refer to: http://www2.illinois.gov/budget/Pages/Resources.aspx or Appendix D.

Major Service Categories, Program Areas and Consolidated Human Services Budget

Service Category	Program Area		FY 10 Budget (Inclusive of state, federal and other funding sources)
Criminal Correctional Sys.	Adult Corrections System		$24,650,600
	Juvenile Justice		$5,198,009
		Sub-total	$29,848,609
Educational Support	Education in the corrections system		$37,163,348
	Health care in schools		$4,568,400
	Mental health care in schools		$3,275,000
	Support for children with disabilities in schools		$2,666,293,544
	Support for special populations		$18,831,569
		Sub-total	$2,730,131,861
Employment	Employment for Ex-Offenders		$8,316,600
	Employment for People with Disabilities		$133,428,448
	Employment for Seniors		$6,391,700
	SNAP and TANF Employment and Training and Other Employment		$40,216,172
		Sub-total	$188,352,920
Health Care and Support	Medicaid and Other Related Medical Assistance Programs		$14,875,155,200
	Health Screening and Support		$102,570,700
	Health Services for Children		$11,546,500
	Health Services for Elderly		$596,244,000
	Reproductive Health and Early Childhood Health		$72,918,660
		Sub-total	$15,658,435,060
Housing	Shelters and Supportive Housing for the Homeless		$26,095,610
		Sub-total	$26,095,610
Individual and Family Support	Child Welfare		$955,381,400
	Early Childhood Education, Development and Parenting		$1,356,459,885
	Domestic Violence, Sexual Assault & Elder Abuse & Neglect		$46,957,100
	Other		$32,444,681
	Senior Services		$33,005,300
	Youth Delinquency / Violence Prevention		$25,582,110
	Youth Development and After School Programs		$22,172,700
		Sub-total	$2,472,003,176
Mental Health	Mental Health Services for General Population		$644,312,058
	Mental Health Services in Corrections System		$3,527,500
		Sub-total	$647,839,558
Nutrition	Food support for low-income families		$307,923,577
	Food support for seniors		$49,645,400
	Food support for children in low-income families		$705,319,100
	Supplemental Nutrition Assistance Program		$2,118,901,101
	Supplemental Nutrition Assistance Program (Admin.)		$209,015,693
		Sub-total	$3,390,804,871
Public Assistance	Child Support		$194,758,900
	Older Adult Assistance		$32,286,900
	Other Income Assistance		$130,742,300
		Sub-total	$357,788,100
Public Health	Inspection		$113,808,400
	Preparedness		$22,357,500
	Public Health Education		$27,986,689
	Research		$8,673,400
		Sub-total	$172,825,989
Rehabilitative/Habilitative Servs	Rehabilitative/Habilitative Services		$2,058,493,793
		Sub-total	$2,058,493,793
Substance Abuse	Substance Abuse Services for General Population		$257,181,800
	Substance Abuse Services in Correction Systems		$14,052,867
		Sub-total	$271,234,667
	Total		$28,003,854,214

Summary of Service Delivery Approaches, Populations Served and Key Programs

Illinois human services programs vary considerably in their service delivery approach. Some programs, such as public assistance, are managed and operated entirely by state agencies. Some are delivered through a mix of state-operated programs and contracts with non-profit service providers. Other services are provided by private for-profit providers, such as medical doctors.

To be eligible for these services, consumers generally have to meet a number of criteria, including low-income threshold, age and / or demonstration of service need. Some services, such as Medicaid, are available to all those who meet the program eligibility criteria. Other services are limited to what can be done up to the level of funding allowed. Also, it should be noted that human services are provided not purely based on needs, but also on what is required by laws and how the service costs can be covered.

Each section of this report details the populations served by human service area. While some areas, such as public health, benefit anyone who drinks water or eats in a restaurant, most human services are geared toward specific populations and / or age groups: pregnant women, newborn children, senior citizens, people with disabilities, ex-offenders and their families, school-age children, people who suffer from mental illness or substance use disorders, people living in poverty who need food, shelter, employment services and income support.

As this range suggests, people seek support from the system at different points in their life and rely on it for different durations, ranging from a few months or years to a life time. People also use the system with different levels of intensity. An important new direction in human services research is the effort to identify and understand the needs of sporadic versus frequent users, so that programs can be designed and delivered based on intensity of need.[1]

It is important to recognize that even those who do not directly use the human services system benefit from it for reasons that reflect personal interests, policy goals and the moral core and code that define societies. Diversion, prevention and employment programs, for example, save tax dollars and increase public safety. Statewide networks providing hunger relief and services to seniors and other vulnerable populations address problems that we cannot solve individually. Taken together, these and the many other programs reviewed in this report represent the current set of public policies on how to best meet the multiple needs of a diverse population that requires short- and long-term solutions.

[1] See *Illinois Families and Their Use of Multiple Service Systems*, by Robert M. Goerge, Cherly Smithgall, Roopa Seshadri and Peter Ballard (Chicago, IL: Chapin Hall, February 2010).

Summary of Key Programs, Target Population and Clients Served				
Section Title	**Key Programs**	**Agency**	**Target Population**	**Clients Served**
Criminal Correctional System	Adult Comm Placements	DOC	Ex-Offenders	4,166
	Day Reporting	DOC		3,722
	Case Management	DOC		n/a
	Community Placements	DJJ	Juvenile ex-offenders	329
Educational Support Services	Sp Ed Personnel Reimbursement	ISBE	Students with disabilities	320,000 out of more than 2 million Illinois students ages 3-21 receive special education services
	Ind with Disabilities Ed. Act	ISBE		
	Sp Ed – Transportation	ISBE		
	Sp Ed - Funding for Children Requiring Sp Ed Services	ISBE		
	Sp Ed - Private Tuition	ISBE		
Employment	Vocational Rehabilitation	DHS	Persons w/ disabilities	44,247
	SNAP Employment and Training	DHS	Adults who receive non-assistance SNAP	3,662 monthly
	Job Preparation	DOC	Ex-offenders	Not avail.
	Title V Employment	DOA	Low-inc. older workers	574 (FY 09)
Food and Nutrition	Supplemental Nutrition Assistance Program	DHS	Low-income individuals	1,600,000
	Child Nutrition Programs	ISBE	School-aged children	
	WIC: Women, Infants Children	DHS	Pregnant women and children	310,000
	Illinois Free Lunch/Breakfast	ISBE	School-aged children	993,000
	Title III Nutrition	DOA	Seniors	112,391
Health Care and Support	Medical Assistance	DHFS	Children, parents, disabled, elderly	2.5 million
	Health Services for Elderly	DOA	Seniors	64,000 (CCP)
	Reproductive Health & Related Services	DHS, DPH	Women, infants	n/a
	Health Screening and Support	DPH	Children, women, those w/ special needs	n/a
Housing and Shelter	Supportive Housing	DHS-HCD	Persons who are homeless or at imminent risk of becoming homeless	8,500
	Emergency & Transitional Housing Program	DHS-HCD		49,500
	Homeless Prevention	DHS-CHP	Households in need of rental/mortgage assistance; utility assistance and supportive service	1,100
	Homeless Youth	DHS-HCD	Homeless children	12,500

	Child Care	DHS-HCD	Low income working families with children	174,500 children (monthly avg)
	Early Childhood Education	ISBE	Children at risk of academic failure; low- to middle-income children	95,123, FY 09 92,000 FY 10 est.
	Foster Homes and Specialized Foster Care	DCFS		24,457
	Institution Group Home Care and Prevention	DCFS	DCFS wards	4,183
	Purchased Care of Adoption Services	DCFS	Adopted children	40,456
	Domestic Violence Prevention and Intervention	DHS-CHP	Families affected by domestic violence	43,713 adults 9,235 children (FY 08)
Individual and Family Support	Title III Social Services	DOA	Seniors	500,000 (all DOA programs)
	State Operated Facilities	DHS-DMH	State Operated Facilities	10,500
	Medicaid billable services	DHS-DMH	Medicaid billable services	107,000
	Capacity grants	DHS-DMH	Capacity grants	175,000
Mental Health	Non-Medicaid	DHS-DMH	Non-Medicaid	68,000
	Child Support Enforcement	DHFS		500,000 families
	Temporary Assistance to Needy Families	DHS	Families with children	32,000 monthly
	Aid to the Aged, Blind and Disabled	DHS	Seniors and persons unable to work due to medical disabilities	30,000 monthly
	Circuit Breaker / Pharmaceutical Assistance	DOA	Low-income seniors and people with disabilities	385,000
Public Assistance	State Transitional Assistance	DHS		9,700 annually
	Inspection, Licensure, Certification	IDPH		
	Preparedness	IDPH		
Public Health	Public Health Education	IDPH	All Illinois residents	
	Home Services Program	DHS-DR	People with disabilities	34,309
Rehabilitative / Habilitative Services	Intermediate Care Facilities for the Developmentally Disabled	DHS-DD	People with developmental disabilities	6,603

	Community Integrated Living Arrangements	DHS-DD		8,296
	State-Operated Dev Center	DHS-DD		2,254
	Day FFS Programs	DHS-DD		11,570
Substance Abuse	Addiction Treatment and Recovery Support Services	DHS	General population, including youth	89,909
	Substance Abuse Prevention	DHS	Youth	248,965
	Substance Abuse Treatment	DJJ	Incarcerated youth/Reentering youth	
	Substance Abuse Treatment	DOC	Incarcerated persons	

CRIMINAL CORRECTIONAL SYSTEM

Overview

The correctional system in Illinois is administered as two separate entities, one for juveniles (those under 18 for the most part) and one for adults. Both operate on a continuum from probation (those arrested and not in prison but still under the jurisdiction of the court)[1] and local jails to prisons and parole / supervision (the supervision for those released from prison).

Human services supported by the state are delivered at every level of the system. Some services are designed to divert people from incarceration. Others are provided to those in prison (some in-prison services are mandated by court cases, including health care) or to those on parole. Services include basic needs such as health care. Others are designed to address the underlying causes of criminal behavior, including mental illness and substance abuse.

Many human services directed at juveniles and adults in the criminal justice system are investments in prevention – reducing future crime and creating productive community members. A one dollar investment in preventive services results in $20 of savings.[2] Out of the over one billion dollars currently spent on correctional institutions, a small portion is spent on services. An even smaller amount is spent on diversion. This section of the report focuses on these services.

Within the corrections system, human services emphasize positive assessment and outcomes, just as it does for the general population. The point of services is to help people build on their skills, attributes and support systems. By shifting the focus from merely punishment or isolation to rehabilitation, incarcerated individuals, their families and their communities all benefit, both socially and economically. Effective rehabilitative human services, both in-prison and in aftercare, can lead to increased employment opportunities, family reunification and community capacity building. All Illinois residents therefore benefit, because recidivism and crime are reduced when former prisoners become productive community members, contributing tax dollars, reducing spending on law enforcement, courts and incarceration and making communities safer.

Another dimension of the relationship between human services and the criminal correctional system is the impact incarceration has on families. Recent research demonstrates that many families and communities served by the Department of Human Services (DHS) require increased services and higher service levels because there is a person or persons with criminal records in their families and in their communities. According to a study by the University of Chicago, released in 2009, even though juvenile incarceration, adult incarceration and substance abuse services were likely to be administered in isolation, many of these individuals and / or their families utilized multiple human services. In the study, 96 percent of families with juvenile incarceration also received other services, 85 percent of families with adult incarceration received other services and 95 percent of families with members who received substance abuse treatment

[1] Probation is operated by counties but funded substantially by state dollars and overseen by the Administrative Office of Illinois Courts.

[2] *The Comparative Costs and Benefits of Programs to Reduce Crime*, The Washington Institute for Public Policy, available at: http://www.wsipp.wa.gov/rptfiles/costbenefit.pdf

also received other human services.[3]

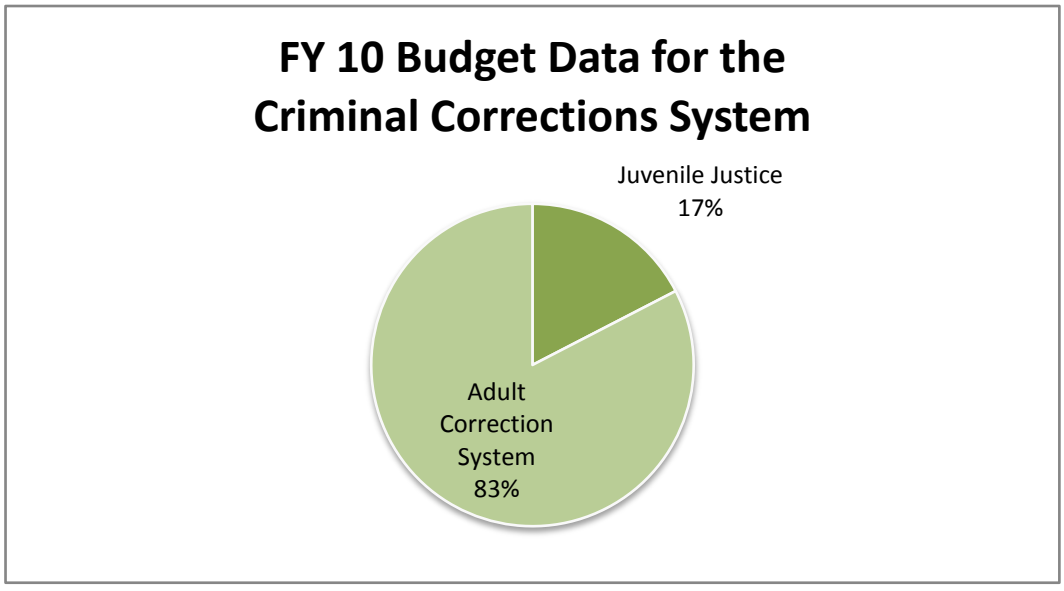
This section of the Human Services Commission report focuses on diversion services for juveniles and adults as well as services offered to those incarcerated and recently released from the Illinois Departments of Corrections (DOC) and Juvenile Justice (DJJ). For the DJJ population, it also includes services funded by the Department of Human Services (DHS). All of these agencies operate diversion programs in the community and a number of in-prison and post-release programs, some autonomously and others in tandem with community-based and faith-based agencies.

According to FY 10 budget data provided by DJJ, DOC and DHS, these services were funded at the following levels:

FY 10 Budget Data for Criminal Correctional System

		Total
	$	29,848,609
Juvenile Justice	$	5,198,009
Adult Correction System	$	24,650,600

These figures are visually illustrated in the following chart:



[3]Illinois Families and Their Use of Multiple Service Systems, Goerge, Robert M., Smithgall, Cheryl, Seshadri, Roopa, Ballard, Peter, University of Chicago. Available at: http://www.chapinhall.org/sites/default/files/publications/Multiplepercent20Systems_IB_03_01_10_0.pdf

ADULT CORRECTIONS

Overview: The role of human services is at the heart of a recent movement in Illinois to identify those who should be incarcerated and those who can be successfully treated either in the community or in confinement. The Crime Reduction Act of 2009 and the creation by the General Assembly of the Illinois Sentencing Policy Advisory Council are designed both to create an appropriate system-wide instrument to assess those in the system and to gather data to understand how best to treat those who can benefit from such services.

Central to the success of the new policies is the principle of rehabilitation for those who are assessed as appropriate candidates for treatment, rather than isolation and punishment exclusively. Research on recidivism and successful prisoner reentry highlight the importance of human services, seen in increased employment opportunities, family reunification, community capacity building and reductions in crime.

Populations served: The number of adults in Illinois within the jurisdiction of the criminal justice system at any time is about 245,000; if these people were residents of a city, it would be the second largest city in Illinois.

On any given day Illinois houses 45,297 adults in its prisons.[4] (Cook County jail alone has 90,000 releases annually—some people are in jail many times in one year.) More than 33,000 adults are on parole and thousands more are in our communities with criminal records and without supervision. Roughly 35,000 individuals are released from prison each year and 35,000 more are incarcerated in Illinois prisons each year – 70 percent for new crimes and 30 percent for parole revocation.[5] The recidivism rate – those returned to prison within three years — is over 50 percent.

Most inmates – 56 percent – are in medium-security facilities. Over 70 percent of the population of inmates is comprised of racial minorities (60 percent African American, 11 percent Hispanic) and 28 percent are white. The average age of an inmate is 34 and he (94 percent are male) is likely to be under-educated (more than half had no high school degree or General Equivalency Diploma when admitted to prison).

Although the average length of sentence at admission is four years, the average amount of actual time served including prison time is 1.9 years.

Substance abuse is both an underlying cause of crime and a crime for which many are incarcerated. In 2004, 72 percent of inmates were convicted of non-violent drug offenses or property crimes that were often drug motivated.[6] More than half of the inmates self reported weekly or daily use of illegal drugs before incarceration, yet only 10 percent reported receiving any sort of drug or substance abuse treatment. DOC estimates that while 80 percent of women in

[4] Illinois Department of Corrections Annual Statistical Report, 2008. Available at: http://www.state.il.us/subsections/reports/annual_report/FY 08percent20DOCpercent20Annualpercent20Rpt.pdf
[5] Id.
[6] Id.

prison (a rapidly growing population of incarcerated persons) need drug treatment, they department is able only able to service 20 percent.[7]

Many have underlying health problems in addition to substance abuse. Fourteen percent of the men and 40 percent of the women entering state facilities reported a history of mental health treatment.[8] A majority come from the Cook County Jail which holds more people with mental illness on any given day than any psychiatric facility in the United States.[9] HIV/AIDS and other infectious diseases disproportionately affect prisoners (HIV/AIDS is estimated to be 14 times higher in prisons than in the general population).[10]

Of the two thirds of prisoners that were employed prior to incarceration, only half of those were employed full time. Of those employed, up to two thirds reported a personal income of less than $1,000 a month.[11] Post releases, according to DOC, 63 percent of parolees were unemployed.[12] When returning prisoners do eventually secure jobs, they tend to earn notably less than individuals with similar background characteristics without a criminal record. The estimated wage penalty of incarceration is at about 10 to 20 percent, significantly decreasing the chances of earning livable wages to support either themselves or their families.[13]

Funding: As noted above, data provided by DOC show the six programs specifically denoted humans services within the Adult Criminal Correctional System were budgeted at just under $25 million.

Service Delivery System: Adult diversion services that are state supported include those delivered by probation departments in the counties, which is beyond the scope of this report. It can be noted briefly that services include an initial assessment and can lead to referrals to organizations such as TASC, where people on probation can receive access to drug treatment services and avoid prison.

Illinois operates two therapeutic prison facilities that focus on drug treatment, rehabilitation and job readiness, one of which (Sheridan) is the largest drug treatment prison in the United States. The Sheridan National Drug Prison and Reentry Program and the Methamphetamine and Reentry Program at Southwestern Illinois Correctional Center focus on intensive treatment, cognitive skills development, vocational and job preparation. These programs are holistic in nature – bridging services from prison to community. According to an Illinois Criminal Justice Information Authority evaluation, Sheridan

[7] http://www.beyondmedia.org/programs/factsheet.pdf
[8] Id.
[9] "Fact Sheet: Mental Illness and Jails," Consensus Project, available at: http://www.floridatac.org/files/document/fact_jails.pdf
[10] Inside Out
[11] From Prison to Work: The Employment Dimensions of Prisoner Reentry, released by the Urban Institute Justice Policy Center, available: http://www.urban.org/UploadedPDF/411097_From_Prison_to_Work.pdf
[12] Inside Out: A Plan to Reduce Recidivism and Increase Public Safety, Report from the Illinois Community Safety and Reentry Commission, available at:
http://www..state.il.us/subsections/reports/other/Governor'spercent20percent20Reentrypercent20Commissionpercent20Reportpercent20FINAL.pdf
[13] From Prison to Home, The Dimensions of Prisoner Reentry, released by the Urban Institute Justice Policy Center, available: http://www.urban.org/UploadedPDF/from_prison_to_home.pdf

participants are 30 percent less likely to recidivate compared to other Illinois releases; 56 percent of the inmates obtained employment while on parole with 86 percent of those being full-time jobs[14].

For those in other prisons in Illinois, there is less programming and it is difficult for many to participate in them because the average length of stay in the system is less than two years, some of which is consumed by assessment and classification when a prisoner first enters the system. Also, the waiting lists are so long that most prisoners leave before they are admitted to a program.

DOC is implementing a Case Management program to develop a reentry plan beginning upon incarceration and continuing through discharge. Additionally, the following programs focus on successful reentry:[15]

- Electronic Monitoring is an enhanced form of supervised release in which a person finds a "host site" where he will stay at all times except when granted movement as permitted by the supervising officer – typically for employment purposes, short family visits and counseling. The more restrictive GPS monitoring is used for sex offenders on parole.

- Day Reporting is part of a matrix of sanctions for parolees exhibiting difficulties complying with parole requirements. This higher level of supervision helps keep parolees in compliance with the terms of their parole and remaining in the community, rather than returning to prison.

- Halfway Back is another step in the sanctions matrix to avoid having parolees return to prison to complete their sentence. Parolees are able to return to custody for short stays to help them get back on track.

- Females in Transition is designed to provide comprehensive post-release services for eligible women.

- Adult Community Placement funding provides support for community-based treatment/placement services to inmates on parole. Safer Foundation, the North Lawndale Employment Network, Treatment Alternatives for Safe Communities (TASC)

[14] David E. Olson, PhD, Jennifer Rapp, Mark Powers, and Steve P. Karr, ICJIA, Sheridan Correctional Center Therapeutic Community: Year 2, Program Evaluation Summary, Vol. 4, No 2, May 2006, http://www.idjia.state.il.us/public/pdf/ProgEvalSummary/Sheridan.pdf.

[15] In addition to the six programs that fall into the Human Services Commission's purview, it should be noted that DOC operates adult transition centers (ATCs), which are minimum security supervision facilities offering reintegration programs and services designed to maximize a person's ability to be self-sufficient, through legal means, upon release. These facilities provide housing, treatment, family reunification, education and job readiness/placement and retention services. ATCs have a track record of success and financial return. The Peoria ATC reported an employment rate of those housed there between 85 and 90 percent. The residents are expected to contribute 20 percent of their earnings based on net income after taxes to offset costs (residents of the Peoria ATC contributed $294,600 in maintenance in 2003). This money is returned to the General Revenue Fund. DOC Website: http://webcache.googleusercontent.com/search?q=cache:pTtljglycAUJ:www.state.il.us/subsections/facilities/information.asp percent3Finstchoice percent3Dpeo+illinois+atc+facilities+percent+recidivism+corrections&cd=1&hl=en&ct=clnk&gl=us

- and St. Leonard's Ministries are some of the organizations that work with people with criminal records in prisons and communities. These organizations have developed models and practices that demonstrate a significant decrease in recidivism.

Beyond these programs, there are a number of post-release initiatives aimed at reducing recidivism. These include the Governor's Statewide Community Safety and Reentry Working Group, a joint effort between DOC and DHS that includes a resource guide for people with criminal records who need job readiness training and job placement.[16] As less than 15 of these programs are offered outside of Chicago, DePaul University's Egan Urban Center has also scanned the state for existing providers in preparation for building a statewide employment and support network when people return to areas not systematically covered today.[17]

Critical Issues and Trends include the following:

- Community Costs: Illinois spends substantial amounts of money on communities with high levels of incarceration. Resources go toward law enforcement as well as human services for families of incarcerated people. Research by Tracey Meares suggests that high levels of incarceration reduce community cohesion, increase problems which require social service intervention and create a cycle of increased incarceration.[18] Todd Clear found that neighborhoods with the highest levels of incarceration in one year had higher than expected crime rates the following year compared to control neighborhoods. He cited as contributing factors the displacement of children with one or more parents incarcerated, the lack of male role models present, a lack of employment opportunities and community resources, and the added stress of having to find alternative ways to support broken families. When also taking into account the deployment of human services, criminal justice, health, and labor resources, research shows that state spending can reach millions of dollars to support a high-risk neighborhood.[19] Much of this money is spent on public assistance to support the unemployed or the under-employed.

  In Illinois, a few communities have disproportionate numbers of people returning from incarceration: 80 percent of people released from state prisons return to just 10 areas. More than half of the state's prisoners return to Cook County, with just six of Chicago's 77

[16] See http://www.reentryillinois.net/. Other may be found at this link: http://euc.depaul.edu/Programs/Evaluations/index.html.

[17] Third party intermediaries play a crucial role in opening up employment opportunities. Harry Holzer's research has found that 60 percent of employers are reluctant to hire a person with a criminal record for a job. However, Holzer also found that a third party intermediary significantly increases the chances that an employer will consider hiring a person with a record. Intermediary agencies and organizations are also important because they maintain contact with individuals and provide on-going support, encouragement and training. Also, agencies may take responsibility for drug testing, transportation, clothing, child care and provide other resources that will remove barriers that interfere with an individual's ability to work. See "How Willing Are Employers to Hire Ex-offenders," Holzer, Harry J., Raphael, Steven, Stoll, Michael A., Taken from three articles published by the authors: "How Do Crime and Incarceration Affect the Employment Prospects of Less-Educated Black Men?" paper prepared for the Extending Opportunities Conference, Washington, DC, 2002; "Perceived Criminality, Background Checks, and the Racial Hiring Practices of Employers," IRP Discussion Paper 1254-02, University of Wisconsin–Madison, 2002; and "Will Employers Hire Ex-Offenders?. Available at: http://www.irp.wisc.edu/publications/focus/pdfs/foc232h.pdf.

[18] Mass Incarceration: Who Pays the Price for Criminal Offending?, Meares, Tracey L., American Society of Criminology, Criminology & Public Policy Journal, Volume 3, Issue 2, pages 295-302

[19] The Collateral Consequences of Mass Incarceration, Todd Clear, available at: http://ccj.asu.edu/events/conferences/downloads/asu-paper-3-todd-clear

communities accounting for 34 percent of the entire reentry population.[20] Predictably, those six communities have below average education levels, below average income, and higher crime rates compared to all Chicago neighborhoods, echoing Clear's research. A significant portion of the budget is dedicated to support a small number of communities, without these communities being in a position to thrive either financially or socially. This means that the state is spending millions of dollars annually while seeing few positive returns.

- Incarceration Affects Children: As Clear points out, a large portion of human services funding is spent to support the children of incarcerated. Approximately 61 percent of incarcerated men polled in a study by the Urban Institute reported having at least one child under the age of 18, and 79 percent of those men provided financial support prior to prison. An inmate profile of women prisoners found that of the 82.5 percent of women with children, 80 percent were the head of single parent households prior to incarceration. In Illinois 90,000[21] children have at least one parent incarcerated, and there is a good chance that the parent was either the primary breadwinner or a significant contributor to the household income. Forty-five percent of incarcerated parents reported living with their child at the time of arrest. As a result children may be displaced or removed from their homes and placed in the State's custody, further driving up costs.

  Beyond the financial costs, many of the children are left without a stable parental presence in their lives and research shows that they are more likely to have trouble in school and more trouble developing the key social skills needed in life. The destabilization of families and communities also creates a cycle of incarceration. In an Urban Institute study[22] of men in jail/prison facilities, 59 percent reported a family member that had been convicted of crime, a third had a family member currently in prison. Seventy-eight percent were first arrested at the age of 18 or younger, further emphasizing the need for community supports and an emphasis on prevention and rehabilitation.

- Role of Vocational Training and Job Placement Support: Research indicates that people who receive vocational training while incarcerated are more likely to be employed following release and to have a recidivism rate that is 20 percent lower than those who did not receive training.[23] Irrespective of whether an individual received vocational training in-prison, finding employment within six months of release also significantly diminishes the chances of recidivating. Further research demonstrates the return on investment for treatment and services up to $7 for every dollar invested.[24]

  Workers living in Chicago south side neighborhoods of Auburn Gresham, Englewood, Washington Heights and West Englewood have an unemployment rate of over 23 percent, more than twice the state average of 11 percent; and up to 70 percent of the male

[20] Inside Out: A Plan to Reduce Recidivism and Improve Public Safety
[21] The Chicago Reporter, Children of the Incarcerated
[22] Illinois Prisoners' Reflections on Coming Home, the Urban Institute, available at: http://www.urban.org/UploadedPDF/310846_illinois_prisoners.pdf
[23] The Report of the Reentry Policy Council, available at: http://reentrypolicy.org/Report/PartII/ChapterII-B/PolicyStatement15/ResearchHighlight15-3
[24] Does it Pay to Invest in Reentry Programs for Jail Inmates, the Urban Institute, available at: http://www.urban.org/projects/reentry-roundtable/upload/roman_chalfin.pdf

population has a criminal record.[25] Job opportunities are limited by low education levels. Seventy percent of people incarcerated do not have a high school diploma. In-prison and in-community job readiness and education programs help individuals not only improve their job prospects, but they improve the quality of their job prospects so that they are able to eventually earn higher wages to care for their families. However, even with job readiness programs in place, securing employment is absolutely necessary to achieve optimal outcomes.

- Need for Mental Health and Substance Abuse Services: Treatment is an important part of the equation. The majority of people released from incarceration battle with addiction and/or mental illness – making their journeys even more difficult and the chances of recidivating even higher. This leaves a significant number of people returning home to face the same temptations that led to incarceration, without access to tools to help them cope.

  Community reentry programs that focus on substance abuse treatment also prove cost-effective in the long run. Incarcerating people for minor drug charges and non-violent offenses costs Illinois taxpayers. In 2002, Illinois taxpayers spent approximately $250 million to incarcerate people convicted of drug offenses – over half were convicted of possession as opposed to drug dealing. There is a particularly high recidivism rate amongst people with a history of substance abuse; this equals millions of dollars being spent annually to incarcerate the same people repeatedly. Drug treatment programs and support services within the community have a significant impact on prison costs by curbing recidivism.

  Illinois spends $20,000-$30,000 per prisoner annually per inmate and the average length of stay in Illinois prisons is 1.9 years. Incarcerating someone convicted of a low-level drug crime for 120 days costs over $7,000.[26] In addition, much of that time is spent in reception and classification, and the relatively short length of stay and complex prison logistics make it difficult for a vast majority of inmates to meaningfully receive human services while incarcerated. On the other hand it would cost less than $4,500 to re-route that same person into a community-based drug treatment program.[27] People who successfully complete treatment with community-based support experience a more speedy recovery in health and behavior. Studies show that treatment focused community supervision for adults lower the recidivism rate by 16 percent and save the community up to 20 dollars for every one dollar invested.[28]

- The Role of Family Support Programs: Family support programs help increase positive outcomes. Results of research conducted by the Urban Institute indicate that family

[25] Inside Out: A Plan to Reduce Recidivism and Improve Public Safety, available at: http://www.idoc.state.il.us/subsections/reports/other/Governor%27s%20%20Reentry%20Commission%20Report%20FINAL.pdf

[26] According to the Illinois Consortium on Drug Policy at Roosevelt University's Institute for Metropolitan Affairs, more information available at: http://illinoisissues.uis.edu/archives/2009/11/state.html

[27] Id.

[28] The Comparative Costs and Benefits of Programs to Reduce Crime, The Washington Institute for Public Policy, available at: http://www.wsipp.wa.gov/rptfiles/costbenefit.pdf

involvement and interaction with the incarcerated individual, particular through programming where there is a third party intermediary involved, can lead to decreased drug use, fewer mental, physical and emotional problems, and decreased recidivism.[29] Post release interviews with formerly incarcerated persons also indicated that families providing critical material and support were important to their success in remaining drug-free, finding employment and obtaining housing. Involving spouses and intimate partners is also important. One study of 650 formerly incarcerated men found that those who were in committed cohabiting relationships were half as likely to commit a new crime eight months after release as those who were not.[30] The quality of the relationship was the determining factor as the decrease in recidivism was tied to either having a significant other that discouraged illegal activity or by indirectly changing patterns and habits that led to criminal behavior.

As it stands, the recidivism rate in Illinois is approximately 52 percent, meaning over half of the people released from incarceration will return to prison within three years; roughly half are rearrested within the first eight months. This impacts not only the convicted person, but families including children, communities, workforce capacity and public safety; not to mention the drain on taxpayers. Money invested in prevention, treatment, rehabilitation and reentry yields tangible results. Job readiness training and a continuum of care from prison to home as well as a presence of community resources and support has a huge impact on whether someone is able to succeed once released from incarceration. Illinois' challenge is to determine strategically how to use its limited resources in order to yield a better return. The expected result must be to identify and offer evidence-based rehabilitative programs and services which reduce recidivism and ultimately increase public safety.

JUVENILE JUSTICE

Overview: Nearly 50,000 youth in Illinois become involved in the justice system each year – a rate of about three percent of all youths ages 10-16.[31] Involvement can range from contact with the police, to an arrest that doesn't lead to further involvement in the system (station adjustment), to probation, to commitment to the Department of Juvenile Justice (DJJ) with a variety of services and interventions in between.

When prevention and diversion efforts fail, courts may commit youth to DJJ custody. DJJ was created in 2006 when the Juvenile Division of DOC was separated into a free-standing agency with a mission to provide treatment and services to enable youth in custody to avoid delinquent futures.

Populations served: DJJ currently houses approximately 1,400 youth in eight institutions (six male and two female). On average, youth remain in DJJ between six and eight months. Youth remain under the supervision of DJJ until they are 21. This is unlike adults, who are released from DOC with a time-limited period of Mandatory Supervised Release (of up to three years). Approximately 2,200 youth are released from DJJ and require aftercare services every year.

[29] The "Returning Home" Project, The Urban Institute, available at: http://www.urban.org/projects/reentry-portfolio/
[30] National Healthy Marriage Resource Center, http://www.healthymarriageinfo.org/docs/IncarcerationFamily.pdf
[31] In calendar year 2007, 48,065 arrests of youth were entered into Illinois' computerized criminal history record (CCH) system, a rate of 3,831 arrests for every 100,000 youth ages 10 to 16.

The majority of exits were by male youth, although in general the percentage of female exits increased slightly in recent years. More than half of the exits were by African American youth. Less than one percent of the population graduated from high school or attained a GED, while most were either grade school graduates or had some high school when incarcerated.[32] Thus, the population for this program mainly represents exits who are in late adolescence. The vast majority of the population was recorded as having used alcohol or drugs. Similarly, most youth exiting had a recorded gang affiliation.

Delinquency and persistence in offending have long been associated with poor academic performance,[33] and incarcerated youth perform at academically low levels and have high rates of failure and grade retention.[34] There is also evidence that many of the youth served by DJJ have suffered abuse and neglect. While many may not be formally in the state child welfare system, at any point in time, there are DCFS wards who are committed to Illinois Youth Center (IYC) facilities.

Studies generally show an association between maltreatment, including physical abuse and neglect, and delinquency.[35] One study of residents of an Illinois girls' prison documents over 80 percent exposure to trauma and abuse.[36] Unpublished work by Chapin Hall shows that about 50 percent of all youth entering DJJ have been a victim of abuse or neglect.

Incarcerated youth have higher than average rates of substance abuse, sexually transmitted diseases, unplanned pregnancies, and psychiatric disorders, all of which can impact behavior and the ability to make healthy decisions.[37] Over 80 percent of the youth in DJJ report using alcohol or drugs.[38]

Funding: According to FY 10 budget data provided by DJJ and DHS, the two juvenile justice programs discussed in this section were funded at $5.2 million.

Service Delivery System: Some programs that serve youth in the juvenile justice system seek to divert youth from further criminal involvement by addressing youths' underlying needs (such as substance abuse, mental health issues, exposure to trauma or educational deficiencies resulting from developmental issues) at the earliest point possible.

However, the agency primarily responsible for youth corrections, DJJ, does not offer diversion programs. Rather, DHS spends tens of millions of dollars annually on prevention and diversion community-based programs that serve youth who have come in contact with the justice system.[39] County-run, but state-funded Probation departments also provide both rehabilitative services and supervision.

DJJ operates eight youth centers around the state. IYC Warrenville and Pere Marquette serve females, while IYC Joliet, St. Charles, Harrisburg, Chicago, and Murphysboro serve males. IYC Kewanee is a special treatment facility that serves males with serious mental illness, substance abuse issues or are sex

[32] Ruth, et al, 2009.
[33] For a detailed review, see Maguin & Loeber, 1996.
[34] For a review, see Foley, 2001.
[35] Maxfield & Widom, 1996; McCord, 1983; Smith & Thornberry, 1995; Widom, 1989.
[36] ICJIA, "Female Delinquents Committed to the Illinois Department of Corrections: A Profile", December, 2003.
[37] See Clark & Gehshan, 2006; Cocozza & Skowyra, K., 2000; Greenbaum et al., 1996; Otto et al., 1992; Steiner & Cauffman, 1998; Stiffman et al., 1997; Timmons-Mitchell et al., 1997.
[38] Ruth, et al, *op cit.*
[39] These are described under the Individual and Family Support Section of this Report.

offenders. St. Charles is the oldest facility, opened in 1904. Kewanee is the newest, opened in 2001. These secure facilities provide assessment and intake for the youth, educational, recreational, counseling and treatment services. The average annual cost to operate these facilities is $85,015 per person.

DJJ must meet federal and state education requirements for youth in its custody and therefore operates its own school district. As discussed in the Educational Support Services section of this report, funding is provided by the Illinois State Board of Education, federal grants, and state appropriations. Youth are initially assessed for math and reading levels, and school transcripts are obtained to gauge scholastic achievement. Youth are placed in classes with others who are working on the same subjects at similar levels. Individual education plans are made to prepare youth for 8th grade or high school graduation, or to take the GED test. At this time, there is legislation pending to guarantee that State Aid is paid at the right levels to DJJ. According to the DJJ, a shortage of resources and of teachers has led to some reduced educational contact hours and reduced special services for educationally needy youth.

Child trauma identification and treatment is currently being piloted in several facilities. Through dollars made available from the Illinois Violence Prevention Authority and the John D. and Catherine T. MacArthur Foundation Models for Change, youth incarcerated in Illinois are being tested for trauma-related problems and staff is being trained to identify and treat the issues.

To successfully return to the community, youth require comprehensive after care services; yet, in Illinois, the aftercare system has not been fully developed. DJJ still relies on DOC parole agents to provide supervision and support for youth exiting. In all but the Cook County region, parole agents have mixed caseloads of adults and youth. According to the John Howard Society, "most parole agents do not see themselves as having a role in seeing that the youth is reintegrated into the community and receives the services needed for success, but rather as having the primary responsibility to insure that parolees do not re-offend."[40]

In addition to supervision, many youth leave DJJ with multiple service needs that must be met in the community. Yet, DJJ has limited funding to provide transition services, such as mental health treatment, sex offender treatment, drug treatment, housing, etc. More than 100 youth at any given time are awaiting placement. DJJ spends approximately $4 million annually to provide services through community-based providers, including residential placement for youth addressing sexual offenses or mental health needs and community-based drug treatment.

DHS also participates in the Juvenile Detention Alternatives Initiative (JDAI). This program relies on data-driven analysis to screen out non-violent, low-risk youth from the early stages of the system (before a court appearance) and enroll them in positive programming while helping them to meet their responsibilities under the legal system.

Critical Issues and Trends: The promise of the creation of the DJJ was to move from a punishment model to a rehabilitative model, a change that hinges on the creation and delivery of: 1) sound rehabilitative human services for those who need to be incarcerated and 2) diversion human services for those who can be treated in the community. DJJ has a Master Plan which describes expansion of services as well as capital improvements to the system. To date, little in the plan has been able to be implemented. Service provision is limited and, for those working in the facilities or in parole (aftercare), there has not

[40] Patricia Connell, *IDFF Facility Site Visits* (Chicago, IL: John Howard Association of Illinois, January 2010), page 4.

been much of the training that should accompany the changes in culture needed to create a rehabilitative service model. Other critical issues include the following:

- Aftercare: A key challenge to ensure the successful return of youth to the community is a comprehensive aftercare system. As described above, DJJ relies on DOC to provide parole agents for downstate youth and these parole agents must serve large caseloads of both adults and youth. In Cook County, aftercare workers, very limited in number, focus solely on youth. Thus, the current approach to supporting youth leaving DJJ cannot be described as a comprehensive aftercare system, the kind that provides an array of mental health, housing, substance abuse treatment, job training or job referrals, educational support and other services necessary to ensure that youth are successful.

- Mandatory Supervised Release Age Limit: Youth remain under the custody of DJJ after they are released until they turn 21. Yet, if they commit a crime when they are technically adults (over the age of 18), no matter when they were released from a DJJ facility, they may be returned to DJJ to finish out their juvenile sentence (when they reach the age of 21). This is a particular issue in Cook County and means that DJJ is quickly filling with what otherwise would be adult offenders who have committed adult offenses. This new, older, more dangerous population limits DJJ's ability to provide the appropriate youth-oriented rehabilitative services and instead diverts resources and staff focus to higher-level security needs.

- Federal Funding: Finally, many services needed by youth in the juvenile justice system are similar to services provided by the child welfare system. Yet, the state has made only limited headway in using federally-funding to expand the array of services made available to youth exiting the juvenile justice system.

Human Services Area: Criminal Correctional System

Data Source: State agencies as indicated in the first column

Juvenile Justice

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DJJ	Community Placements	To provide community-based treatment/placement services to juveniles on parole	To provide a community based infrastructure to reduce failure rates and recidivism.	$4,139,009
DHS-CHP	Juvenile Justice Disproportionate Minority	The goal of IJDAI is to ensure the safe custody of those youth who pose a clear threat to personal safety and to prevent the inappropriate and unnecessary use of secured detention for youth that do not pose a threat to public safety or are at risk of not making their court appearance date.	Balanced and Restorative Justice	$1,059,000

Adult Correction System

DOC	Adult Community Placements	To provide community-based treatment/placement services to inmates on parole	To provide a community based infrastructure to reduce failure rates and recidivism.	$8,044,500
DOC	Day Reporting	Aspect of sanctions matrix for parolees exhibiting difficulties complying with parole requirements.	Facilitating successful re-entry in lieu of parole violation.	$5,825,600

DOC	Case Management	To facilitate reentry from day one of incarceration through discharge.	Successful reentry - reduced recidivism.	$4,347,000
DOC	Electronic Monitoring	To provide electronic and GPS monitoring for sex offenders on parole.	To protect the public as much as possible from sex offenders on parole status	$3,700,000
DOC	Halfway Back	Aspect of sanctions matrix for parolees exhibiting difficulties complying with parole requirements.	Facilitating successful re-entry in lieu of parole violation.	$2,480,000
DOC	Females in Transition	To provide comprehensive post release services /transitional services and placement for eligible women	Decrease in the number of female repeat offenders; increase in the # of women in stable living arrangements and engaged in services	$253,500

EDUCATIONAL SUPPORT SERVICES

Overview

All persons in Illinois have a right to public education through the 12th grade. Where specific populations have challenges in accessing an education, and where we have learned that other supports are needed, the state has responded by developing and funding educational supports that enhance and augment learning in the schools or, in some cases, at alternative facilities. These programs serve children, youth and adult learners in a variety of settings, including schools, children's homes[1] and correctional facilities.

With one exception noted below, this report focuses on services that are classified as *educational support*, that is, support for children with disabilities in schools; mental health care programs in schools, school health centers, support for special populations, including homeless students and orphans, as well as education in the corrections system. The scope of the Human Services Commission does not cover the education system per se, so the reader will not see general education funding or higher education discussed here.

Federal law requires each state to designate a State Education Agency in order to receive federal funds. In Illinois, the Illinois State Board of Education (ISBE) serves that role. ISBE is responsible for disbursing federal and state funds to local education agencies or school districts. In addition to its role in the disbursement of funds, ISBE also oversees and monitors the implementation of state and federally required programs, ensuring local district compliance.[2] It is important to note that ISBE serves largely as a fiscal agent and that local school districts make most of the decisions about educational support services unless they are federally mandated services under the Individuals with Disabilities Education Act (IDEA). For those services, there is no flexibility in how they are funded or delivered.

In addition to ISBE, other state agencies involved in providing educational support are the Illinois Department of Corrections (DOC), Illinois Department of Juvenile Justice (DJJ) and the Illinois Department of Human Services (DHS). The programs they offer that are discussed in this section target children K-12,[3] or provide continuity of education to young people involved in the corrections system,[4] or educate adults in the corrections system. Programs discussed in this section include the following:

- Special education: IDEA is the vehicle by which students with disabilities access Free Appropriate Public Education (FAPE). IDEA provides special education to eligible students with disabilities in the least restrictive learning environment.

[1] I.e., orphanages. Since that word has negative or archaic connotations for many, the term "children's home" is used in this discussion.

[2] Local Education Agencies (LEAs) are their own separate governmental agencies responsible for a number of locally controlled decisions, such as curriculum and personnel. LEAs are governed by an elected Board that hires a Superintendent for oversight of day-to-day activities of the district.

[3] Early childhood education programs closely relate to the K-12 education system, since they prepare children to enter school ready to learn. See the Individual and Family Support section for a discussion of these programs, including Early Childhood Block Grant Programs (preschool services for 3- and 4-year-olds and developmental services for at-risk infants and toddlers); prevention, early intervention and treatment services; home-visiting programs such as Healthy Families Illinois and Parents Too Soon; child care assistance; and after-school programs.

[4] For youth committed to DJJ facilities, the state provides all of their education, not just educational supports. It is of note that DJJ's school district is the only public school district in Illinois that operates within a state agency.

- Mental health services: The Children's Mental Health Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP) and charged it with developing a Children's Mental Health Plan. This includes short-term and long-term goals for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth to age 18 and for youth ages 19 to 21 that are transitioning out of key public programs.

- School Health Centers, which emerged in the late 1960s and early 1970s to respond to increased knowledge about the risk-taking behavior of adolescents and provide accessible, affordable primary health care and health education to children and youth. There are 46 School Health Centers in Illinois. Approximately one-third serve high schools and the rest serve elementary and middle schools. The Department of Human Services (DHS) oversees School Health Centers.

- Programs that educate young people and adults who are or have been incarcerated. For school-age children, DJJ programs insure that they can continue to learn while incarcerated. For young adults, DOC's programs address functional academic skills in reading, writing, and mathematics, to help reduce recidivism and position people for employment opportunities upon release.

Populations Served

Approximately 14 to 20 percent of students face serious emotional or behavioral challenges that interfere with their ability to learn.[5] As of 2008, close to 320,000 out of more than 2 million Illinois students ages 3-21 were receiving special education services. To qualify for IDEA, a child must meet the eligibility criteria in one of thirteen qualifying disabilities that create a hindrance in his or her education. Thus, eligibility for IDEA depends upon the severity of the impairment of a child. IDEA requires written documents in relation to identification, evaluation and placement of a child.

School Health Centers serve approximately 24,000 children and adolescents per year, many of whom do not have insurance and / or access to primary care services for preventative care and treatment. According to the Illinois Coalition for School Health Centers, one in seven teens has no health insurance and private health insurance plans frequently place restrictions on services for teens.

According to data provided by DJJ, approximately 2,500 youth received their education while in juvenile facilities. Budget data from DOC report that of the 45,000 inmates in adult prisons, only 8,200 – 18 percent – currently participate in education support programs.[6]

Other educational support programs serve children who live in children's or foster homes or who are homeless, 26,460 of the latter received education support services in FY 10.

Service Delivery System

[5] O'Connell, Mary Ellen et. al., 2009

[6] See the Corrections section of this report for additional information about this population.

Each child receiving IDEA educational support services has an Individual Education Plan that identifies the education goals, and needs of the child and serves as a blueprint for service delivery. Services are delivered through local school districts.

A key issue in the service delivery system is that many of the services children are eligible for also qualify for other federal funding, such as Vocational Rehabilitation. Families can find themselves in the middle of a system debate over whether the school district (and sometimes state Vocational Rehabilitation) should be paying for a service.

School health centers, located within school buildings or connected to schools in community based health settings, provide primary and preventive health care services to students. These services reduce lost school time, remove financial barriers to care and promote family involvement. School health centers are planned partnerships between health care providers, school districts, local health departments, clergy, community leaders and organizations, parents and students.

A student's encounter with a School Health Center is often his or her first encounter with any health care provider. They play a cost-effective role in providing preventive services that reduce potential for engagement in high-risk behaviors at an early age, thus preventing the need for acute care in the future. Research on School Health Centers finds that this care leads to fewer school absences, higher compliance with required immunizations and physical exams, decreased smoking of tobacco and marijuana, fewer hospitalizations and emergency room visits and a decline in teen pregnancy.

DOC provides the following academic programs at its facilities: basic education, ESL, GED prep, special education, literacy, non-degree college courses, and two- and four-year college degrees. It also provides vocational education in automotive, business management, custodian, computers, construction, cosmetology, dog grooming and training, drafting, electronics, food service, horticulture, laundry, print management and tech-related math.

Juveniles in the corrections system are educated within one of eight DJJ facilities, receiving a minimum of 20 hours per week of instructional and career programming. Classes are offered in basic and special education along with some vocational education including: automotive, business management, custodian, computers, construction, food service, horticulture, small engines and wood working. Although education is required, only 91 percent of youths participate.

The value of these investments is clear: A study by the Correctional Education Association found that "correctional education participants had statistically significant lower rates of re-incarceration (21 percent) when compared to the control group of non-participants (31 percent)." This equates to a 29 percent decrease in recidivism.[7] Currently, however, both DJJ and DOC education programs are struggling to meet needs due to a lack of educators.

For orphaned and homeless children, services are delivered through local educational agencies and school districts. Homeless children receive supports and advocacy services to help them remain enrolled in school.

Funding

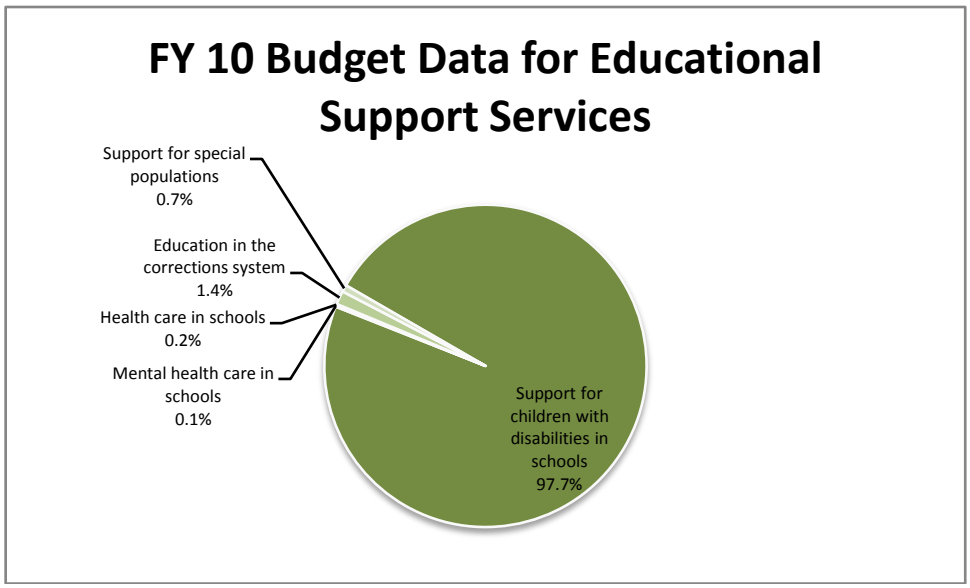
[7] *Three State Recidivism Study*, by Steurer, S., Smith L., Tracy A. (Correctional Education Association, 2003).

The educational support programs discussed in this section were funded at the following levels in FY 10, according to budget data provided by DHS, DOC, DJJ and ISBE:

FY 10 Budget Data for Educational Support Services

	Total
	$2,730,131,861
Support for children with disabilities in schools	$2,666,293,544
Mental health care in schools	$3,275,000
Health care in schools	$4,568,400
Education in the corrections system	$37,163,348
Support for special populations	$18,831,569

The distribution of funding is visually illustrated in the following chart:



Fully 97 percent of the budget consists of IDEA mandated services. These educational support services are funded by federal monies along with state maintenance of effort requirements for special education related spending that is part of mandated categoricals pursuant to the IDEA. Under these mandates, expenditures must be maintained at the level of the preceding year. In addition, to receive certain ARRA (stimulus) funds, Illinois committed to maintain spending for General State Aid and mandated categoricals at the FY 06 level of $5.3 billion.

The Philip J. Rock School, Autism Services and Materials for the Blind and Deaf are the only programs that have state funding discretion. The state appropriation to ISBE for the Illinois Children's Mental Health Partnership (ICMHP) is directly related to The Children's Mental Health Act of 2003. The FY 10

appropriation funds the state's Positive Behavioral Interventions and Supports (PBIS), Social, Emotional Learning (SEL) Professional Development and School Mental Health (SMH) Initiatives.

It is important to note that there are always many more applications for these programs than dollars available. For example, for the FY 10 Integrating Mental Health in Schools Request for Proposals, there were 37 Districts (serving around 50,000 students) requesting over $1.9 million. Out of those requests, only 12 Districts (serving around 22,000 students) were funded.

ISBE also received ARRA monies to supplement existing services, dollars that must be spent by the end of the federal fiscal year. This means educational support services successfully avoided cuts in 2010, but are likely to experience funding challenges in 2011. As of this writing, the proposed 2011 budget falls short of IDEA maintenance of effort requirements, which Illinois would need to remedy or else be penalized with a loss of federal dollars.

In 1998, school health centers were granted their own provider type under Illinois' Medicaid program, allowing eligible centers to bill Medicaid at fee-for-service reimbursement. Medicaid certifies the expenditures incurred by the school and returns the federal matching funds to the school district. In 1999, tobacco settlement funding was allocated for school health centers which allowed for establishment of new school health centers across the state and an expansion of services at existing centers.

Funding support for corrections education programs has declined significantly since FY 2001, according to Illinois Budget Book data. While spending totaled over $44 million in FY 01, FY 09 actual expenditures were just below $32 million. This is a non-inflation adjusted 28 percent reduction in funding.

Critical Issues and Trends

As noted above, approximately 14 to 20 percent of students face serious emotional or behavioral challenges that interfere with their ability to learn. This is a significant issue for a state that has more than 2 million students attending public school. In schools serving low-income students, this percentage increases to as high as 50 percent.[8] The President's New Freedom Commission on Mental Health emphasizes that "strong school mental health programs can reduce unnecessary pain and suffering and help ensure academic achievement."[9]

The importance of school-based mental health services and supports to improving academic outcomes is underscored in several national initiatives including No Child Left Behind (NCLB), Response to Intervention (RtI), PBIS and the SEL Standards Project. Each of these initiatives is designed to promote prevention in order to ensure that school-based intervention efforts have a greater likelihood of success.[10] Both research and current practice in Illinois point to the effectiveness and cost benefits of prevention and early intervention services and yet a key barrier to the full integration of education supports including mental health services is the limited and fragmented funding stream.

For the adult and juvenile corrections system, a major determinant of the availability of education is more straightforward: it is the availability of sufficient teaching staff. State staffing dropped

[8] Center for Mental Health and Schools, 2003
[9] http://www.mentalhealthcommission.gov/FAQs.htm
[10] *School Based Mental Health in Illinois: Assessing the Present and Looking toward the Future*, in press, 2010.

precipitously after the early retirement program in FY 03, and the educational systems in both departments are only now being slowly restored. As a result, DJJ and DOC education programs are struggling to meet the need due to a lack of educators. While there were 297 educators working in 2001, there were only 206 at the end of 2009 – a 31 percent reduction.[11] Outcome measures show the impact of those reductions. Participation in DJJ education programs is down 8 percent compared to 2001, and adult participation declined 35 percent.[12]

The discussion of school health centers signals a larger trend that bears notice: The "community school" model, which is transforming the traditional school into a hub of the community by linking existing school and community resources and identifying new ones. Its integrated focus on academics, health and social supports, and parent and neighborhood involvement leads to improved student learning, stronger families and healthier communities. Research has shown that students in community schools demonstrate increased academic success, a positive change in attitudes toward school and learning, and decreased behavioral problems. There are already more than 200 identified community schools in the state. Approximately 100 additional Illinois schools, serving close to 25,000 students, have expressed interest in becoming a community school, but lack the resources needed to make the transformation.

[11] According to worker counts in "educator" title from AFSCME/CMS records.
[12] Data from *Quarterly Report to the Legislature* published by DJJ and DOC.

Human Service Category: Educational Support Services

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
Support for Children with Disabilities in Schools				
ISBE	Individuals with Disabilities Education Act	To provide supplemental funds to ensure all children with disabilities ages 3-21 receive a free appropriate public education in the least restrictive environment. Funds are used for teacher/aides salaries, other personnel (e.g. social workers, psychologists, physical therapists), training, specialized consultants, and instructional supplies, materials and equipment.	To assist local school districts and service provider agencies to help meet the needs of students with disabilities ages 3-21.	$570,000,000
ISBE	Individuals with Disabilities Education Act - ARRA	To provide supplemental funds to ensure all children with disabilities ages 3-21 receive a free appropriate public education in the least restrictive environment. Funds are used for teacher/aides salaries, other personnel (e.g. social workers, psychologists, physical therapists), training, specialized consultants, and instructional supplies, materials and equipment	To assist local school districts and service provider agencies to help meet the needs of students with disabilities ages 3-21.	$506,479,753
ISBE	Sp Ed - Personnel Reimbursement	To employ staff to serve children and youth with disabilities, ages 3-21 years old. Specialized staff includes teachers, school social workers, school nurses, school psychologists, school counselors, physical and occupational therapists, individual or classroom aides, readers, administrators and others.	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$459,600,000
ISBE	Sp Ed - Transportation	To provide transportation reimbursement to schools for students with disabilities who have special transportation needs as stated in their individualized education program.	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$429,700,000

ISBE	Sp Ed - Funding for Children Requiring Sp Ed Services	To supplement funding to local school district expenditures for students with disabilities.	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$334,236,800
ISBE	Sp Ed - Private Tuition	To provide special education services in private facilities for children with disabilities when the public school system does not have the necessary resources to fulfill the students' educational needs.	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$181,100,000
ISBE	Sp Ed - Orphanage Tuition	To reimburse school districts for providing special education services to children residing in orphanages, children's homes, foster family homes or other state-owned facilities.	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$120,200,000
ISBE	Individuals with Disabilities Education Act - Preschool	To help local school districts and special education cooperatives offer more comprehensive programs for children with disabilities - ages three through five - by employing teachers and aides, purchasing materials and supplies, and providing related services, training and consultation.	To support schools developing a comprehensive early learning system that enables all children with disabilities to meet the Illinois Learning Standards by age three.	$25,000,000
ISBE	Individuals with Disabilities Education Act - Preschool - ARRA	To help local school districts and special education cooperatives offer comprehensive programs for children with disabilities ages three through five. Funds are used for teacher/aide salaries, other personnel providing related services (e.g. social workers, psychologists, and physical therapists), materials and supplies, training and consultation.	To support schools providing appropriate special education programs for children with disabilities ages three through five.	$18,311,491
ISBE	Sp Ed - Summer School	To provide educational services through the summer for students with disabilities so that they do not lose what progress was made during the regular academic year in private placements (see Special Education – Private Tuition) or in public school programs (see Special Education – Funding for Children Requiring Special Education Services).	To support the delivery of required services to students with disabilities by approving and distributing state funding for special education services.	$11,700,000

ISBE	Philip J. Rock Center and School	To provide for a statewide center and a school for individuals who are both deaf and blind. Deaf-blind students require highly specialized and personalized teaching approaches and special adaptations in instruction in both the auditory and visual modes to promote maximum learning.	To meet the educational needs of deaf-blind students throughout Illinois.	$3,577,800
ISBE	Individuals with Disabilities Education Act - State Improvement	To continue and expand the implementation of the practices begun under the Illinois Alliance for School-based Problem-solving and Intervention Resources in Education (ASPIRE), a coordinated, regionalized system of personnel development. This system is designed to increase the capacity of school systems to implement a multi-tiered model of instruction, assessment and interventions, including response to intervention (RtI), and provide early intervening services to at-risk students and students with disabilities, as measured by improved student progress and performance.	To increase the capacity of school districts to deliver high quality, scientific, research-based instruction, assessment and interventions to students who are at-risk of academic failure	$3,200,000
ISBE	Materials Center for the Visually Impaired	To purchase and distribute on a statewide basis Braille and large-print books, adapted materials, and assistive technology equipment for students with visual disabilities.	To support the delivery of required services to students with visual disabilities by approving and distributing state funding for special education services.	$1,421,100
ISBE	Blind and Dyslexic	To increase academic achievement of students with visual and reading impairments by converting printed educational materials into recordings, computerized documents and other accessible formats (e.g., digital audio textbooks with navigation features) to enhance the ability of visually impaired children to keep up with their peers.	To assist local school districts, state agencies and other service provider agencies to meet the needs of at-risk students.	$816,600
ISBE	Individuals with Disabilities Education Act - Deaf and Blind	To provide technical assistance, information, and training to address the early intervention, special education, and transitional and related service needs of children with deaf-blindness, and also enhance state capacity to improve services and outcomes for children and their families.	To provide supplemental funds for services for deaf-blind children ages birth through 21.	$450,000

ISBE	Individuals with Disabilities Education Act - Model Outreach	To assist local Individual Education Plan teams to improve the transition planning and service delivery process through the implementation of research-based transition practices that result in improved student outcomes	To assist local Individual Education Plan teams to improve the transition planning and service delivery process through the implementation of research-based transition practices that result in improved student outcomes	$400,000
ISBE	Autism	To provide consultation, technical assistance and training for families of students with autism and the school staff serving these students.	To build local capacity to establish and implement effective educational supports and services in the least restrictive environment for students with Autism Spectrum Disorders.	$100,000

Mental Health Care in Schools

ISBE	Children's Mental Health Partnership	The Children's Mental Health Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP) and charged it with developing a Children's Mental Health Plan, which includes short-term and long-term goals for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth to age 18 and for youth ages 19 to 21 who are transitioning out of key public programs.	To expand and improve the quality of mental health services available to students.	$2,700,000
ISBE	Community and Residential Services Authority	To develop collaborative and coordinated approaches to service planning and service delivery for individuals through the age of 21 who have behavior disorders and/or are severely emotionally disturbed and who typically require coordinated services from multiple agencies. Funds are used to develop and implement a statewide plan for service delivery and maintain an interagency dispute resolution process.	To advocate, plan and promote the development and coordination of a full array of prevention and intervention services to meet the unique needs of children and adolescents who are behavior-disordered or severely emotionally disturbed.	$575,000

Health Care in Schools

DHS-CHP	School Health Centers	The purpose of the school health center is to improve the overall physical and emotional health of students by promoting healthy lifestyles and by providing easily accessible preventive and acute health care when it is needed.	Improve Adolescent Health	$4,244,400
DHS-CHP	School Health	To equip school staff with the knowledge and skills to improve the health and well being of school-aged children statewide	Improve Adolescent Health	$324,000

Education in the Corrections System

DOC	Education Programs	To provide education programming to inmate population (includes ABE, Special Education, GED, Vocational education)	To increase educational skills for inmates committed to the Department which contributes to reductions in recidivism.	$25,832,200
DJJ	Education Programs	To provide education programming to juvenile population (includes K-12, Special Education, GED, Vocational education)	To increase educational skills for youth committed to the Department which contributes to reductions in recidivism.	$11,331,148

Support for Special Populations

ISBE	Orphanage Tuition	To reimburse school districts for providing educational services to children residing in orphanages, foster homes, children's homes, state welfare or penal institutions and state-owned housing in lieu of the local property tax revenue associated with such children.	To provide eligible entities Regular Education Orphanage funding to support local educational services.	$13,000,000
ISBE	NCLB - Title X - Homeless Education	To address the problems that homeless children and youth face in enrolling, attending and succeeding in school. The state agency ensures that homeless children and youth have equal access to the same free, appropriate public education as provided to other children and youth.	To provide support and technical services, outreach and advocacy needed by homeless students to remain enrolled in school and to achieve the Illinois Learning Standards.	$3,250,000

ISBE	NCLB - Title X - Homeless Education – ARRA	To address the problems that homeless children and youth face in enrolling, attending and succeeding in school. The state agency ensures that homeless children and youth have equal access to the same free, appropriate public education as provided to other children and youth.	To provide support and technical services, outreach and advocacy needed by homeless students to remain enrolled in school and to achieve the Illinois Learning Standards.	$2,581,569

EMPLOYMENT

Overview

Unemployment and underemployment lie at the core of poverty.[1] Labor is often the most critical asset people can use to improve their economic security and general well-being. Hence the provision of effective employment and training (E&T) opportunities is essential for achieving poverty reduction and sustainable economic and social development. Given employment's importance, job training and improving access to employment occupy a central place in poverty reduction strategies and, by extension, the human services system.

For people whose success in work is challenged by barriers – a lack of skills and experience, a history of unemployment, disabilities, past incarceration, age-related issues – the human services system helps them to secure and be successful in employment. This section of the report focuses on the range of job-related services and supports for people facing a wide array of barriers.

Due to the many different populations and distinct programs involved, this section is organized according to program area and the populations served. Each subsection covers the same set of points (population characteristics, service delivery system, funding, critical issues and trends) discussed in other sections of this report.

This section specifically covers employment programs managed by the Illinois Department of Human Services (DHS), Department of Corrections (DOC) and the Department of Aging (DOA). It does not include the state's largest overseer and provider of employment programs and services, the Illinois Department of Commerce and Economic Opportunity (DCEO), because that agency is not covered by the Executive Order establishing the Human Services Commission. Given the importance of DCEO employment programs, an overview of them, including funding levels, is provided in Appendix E.

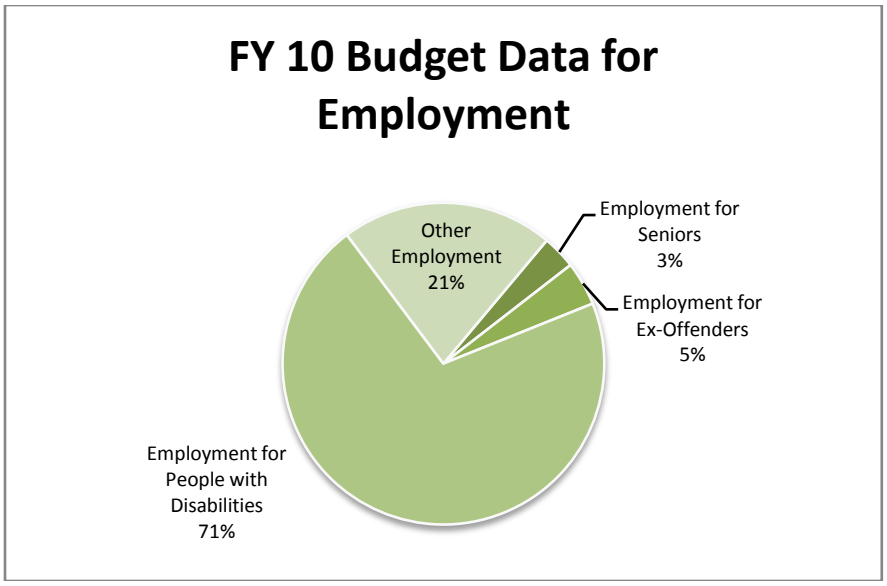
FY 10 budget data provided by DOA, DOC and DHS show the following allocations of funding for the employment services discussed in this section:

FY 10 Budget Data for Employment

	Total
	$188,352,920
Employment for Seniors	$6,391,700
Employment for Ex-Offenders	$8,316,600
Employment for People with Disabilities	$133,428,448
SNAP and TANF E&T and Other Employment	$40,216,172

These allocations are visually illustrated in the next chart:

[1] UN Department of Social and Economic Affairs. (2010, May 13). *Poverty and Employment*. Retrieved May 13, 2010, from Social Perspective on Development Branch: http://www.un.org/esa/socdev/social/poverty/poverty_and_employment.html



Funding for employment programs originates at the federal and state levels, although the former is by far the more significant source. Federal dollars consist of block grants or competitive awards, depending on the specific program. As noted in several areas below, in federal FY 10, funds from the American Recovery and Reinvestment Act (ARRA) have played a large role in some programs, though its duration is limited to one year. The amount of discretion afforded to Illinois in implementing services also differs from one type of service to another. Further details on this funding picture are included in the program-based discussions, below.

Populations Served, Service Delivery System, Funding and Critical Trends by Area

SNAP AND TANF EMPLOYMENT AND TRAINING

Overview: For people with limited or no work experience, barriers to employment may include low literacy and math skills, limited job-related skills and an overall unfamiliarity with the world of work. Through the Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T), eligible recipients engage in work-related activities as a condition of receiving food assistance benefits.[2] Similarly, DHS invests in workforce development activities and programs for recipients of cash assistance under the Temporary Assistance for Needy Families (TANF) program.

SNAP benefits (formerly food stamps) are further described in the Food and Nutrition section of this report and TANF is described in the Public Assistance section; however, the E&T component of both programs will be covered here. Both programs include an employment component, linked to the food or cash benefits, that is required by federal law. However, the state has flexibility as to how it designs the employment component and what models are implemented.

[2] The Food and Nutrition portion of this report covers the non-employment and training aspects of the SNAP program.

The mandated SNAP E&T program requires participation in a variety of E&T work activities in order to maintain eligibility to receive food assistance. This connection has been suspended by ARRA until September 30, 2010. However, Illinois has continued to offer SNAP E&T work activities to participants as a way of encouraging individuals to obtain work skills, experience and employment. Work programs included under SNAP E&T include Earnfare, an employment program for adults without dependents; Non-custodial Parent Earnfare, a program for unemployed parents who do not have custody of their children who receive TANF and often SNAP benefits; and job placement and special projects which help individuals find and maintain unsubsidized employment.

E&T services for TANF recipients and other low income TANF eligible families help individuals develop job skills necessary to obtain and maintain employment and become self sufficient. Specific programs include:

- Job Placement, which assigns participants to work and training activities in order to gain job skills and be placed into unsubsidized employment.
- Work First, a pay-after-performance program in which the participants earn their TANF assistance grants through participation in the program and assigned activities.
- Transitional Jobs, which provides intensive case management, wraparound services and subsidized employment placements to assist customers in gaining unsubsidized employment and achieve a higher level of self-sufficiency.
- TANF Special Projects, which are individually negotiated services to address specific barriers and/or employability needs.

Populations served: All states must provide a SNAP (formerly food stamp) E&T program for able-bodied adults without dependants, age 18-49, who are not disabled or considered exempt. All individuals participating in SNAP must meet work requirements in order to receive SNAP benefits, which can accomplished by: being employed at least 80 hours per month, participating in a work program activity for 80 hours per month, or participating in a SNAP work activity in which they work off the value of their SNAP benefits. The SNAP E&T program also serves non-custodial parents of TANF-receiving children who are under a court order to take part in the Earnfare program. Individuals may be exempt from SNAP E&T participation due to health issues, participation in a recognized school or training program, caring for an incapacitated person, or participating in drug/alcohol treatment or rehabilitation programs. In many cases these individuals have barriers to employment that require specific services and supports to manage and overcome. Currently, 3,662 people are served in the SNAP E&T program each month.

TANF E&T programs serve TANF recipients and TANF-eligible families, which are generally low-income families with children under the age of 19, including low-income pregnant women who may or may not already have children. Work activities are mandated for non-exempt adults whose families receive TANF benefits. The TANF Job Placement program serves 1,136 individuals and places 566 in unsubsidized jobs with retention. Work First serves 1,376 individuals and places 688 in unsubsidized jobs with retention. Transitional Jobs serves 143 customers and places 121 in unsubsidized employment with retention.

Service Delivery System: SNAP and TANF recipients are assessed and referred from DHS Division of Human Capital Development (DHS-HCD) local offices to community-based providers who have contracts to provide E&T services. In addition, outside of Chicago, a variety of businesses, community organizations and governmental entities may contract with DHS to administer these programs.

SNAP and TANF E&T services are delivered in a variety of settings, including the DHS community offices and facilities of partnering organizations, providers and employers. Services provided include case management, job readiness skills, subsidized placement and basic education. Support services include money for transportation or child care, and fees for book or supplies.

All individuals who participate in SNAP E&T are assigned to a required number of participation hours, based upon the food assistance allotment and/or the component activity into which they are placed. Participants work off the value of their food assistance benefit at the state or federal minimum wage, whichever is higher, up to a maximum number of hours per month. Failure to comply with SNAP E&T participation requirements and work activities can result in reduced or discontinued SNAP benefits. Similarly, non-exempt adults whose families receive TANF benefits are mandated to meet work requirements as a condition of receiving benefits. Single parents who are able to work must work or participate in a work activity for at least 30 hours per week; two-parent families are required to work 35 hours per week. Hours spent in programs for substance abuse, domestic violence and mental health count toward meeting work requirements.[3]

Funding: DHS has reported that $$9,945,318 was included in the FY 10 budget for SNAP E&T and $19,313,950 for TANF E&T. The Food and Nutrition and the Public Assistance sections of this report further discuss the funding streams and financial context of the SNAP and TANF programs, respectively.

Critical Issues and Trends: As noted above, all states are required to have E&T programs for SNAP and TANF recipients who are not exempt from working. Illinois has options on how to fulfill these requirements, in order to ensure that programs lead to not only participant compliance, but also lasting employment. This flexibility means that efforts to build on this report and develop recommendations could start by examining the effectiveness of the current SNAP and TANF E&T programs compared to other employment strategies, with the goal of investing in those that produce the best results and ultimately help Illinois strengthen its workforce.

EX-OFFENDERS

Overview: DOC offers vocational training and a number of employment services to assist prisoners with reentry, many of which fall outside of the focus for this report.[4] Services to address work barriers usually include education, skill building and work experience, often coupled with support services such as job readiness and case management. The primary goals in this area are to reduce recidivism and build self-sufficiency through employment. Research indicates that people who receive vocational training while incarcerated are more likely to be employed following release and to have a recidivism rate that is 20 percent lower than those who did not receive training.[5] Growth in number of ex-offenders means

[3] For more information on TANF, see the Public Assistance section of this report. For more information on work requirements, see http://www.dhs.state.il.us/page.aspx?item=38464

[4] Programs that are not within the human services system are worth noting: They include work release centers, or adult transition centers, that provide reintegration programs focusing on education, vocational training, life skills, substance abuse, and employment. Employment is considered primary programming for these centers. Eight Spotlight Reentry Centers also exist in high-impact regions of Illinois that serve as resource centers in providing counseling, programs and services to support parolees' transition into society, including employment. See the Criminal Correctional System section of this report for more information about these programs.

[5] The Report of the Reentry Policy Council, available at: http://reentrypolicy.org/Report/PartII/ChapterII-B/PolicyStatement15/ResearchHighlight15-3

the stigma of a criminal record is an increasingly common barrier to work. Ex-offenders tend to experience higher levels of unemployment, a lack of job skills, interrupted career histories and lower earnings.

Studies have found that financial instability extends to the families of prisoners and may have intergenerational consequences:[6] "One might argue that in light of the potentially permanent consequences of an incarceration spell, the high incarceration rate among black males is perhaps one of the chief barriers to their socioeconomic progress."[7]

Populations served: Policies enacted over the past 25 years have greatly increased the number of people involved in the criminal justice system, doubling Illinois's prisoner population since 1990. If current incarceration rates go unchanged, about one in three black males, one in six Hispanic males and one in 17 white males are expected to go to prison during their lifetimes. Nearly nine times as many men as women have been in prison. A man has a one in nine chance of ever going to prison while a woman has a 1 in 56 chance.[8]

A criminal record has a negative effect on future employability and income.[9] Many ex-offenders were unemployed just prior to their arrest.[10] Of the two thirds of prisoners that were employed prior to incarceration, only half of those were employed full time, and of those employed, up to two thirds reported a personal income of less than $1,000 a month.[11] Only 14 percent of Illinois prisoners have a job lined up after release.[12] Less than half had a high school education before entering prison, and 34 percent had been fired from a job at least once.[13] When returning prisoners do eventually secure jobs, they tend to earn notably less than individuals with similar background characteristics without a criminal record. The estimated wage penalty of incarceration is at about 10 to 20 percent, significantly decreasing the chances of earning livable wages to support either themselves or their families.[14]

Service Delivery System: In all 28 DOC facilities, a 60-hour course is offered that includes creating a resume and cover letter. Participants get a take home packet with workforce information and a certificate of completion. Illinois's two therapeutic prison facilities, located at the Sheridan Correctional Center and the Southwestern Illinois Correctional Center, offer more in-depth vocational and job preparation services.[15] Post-release, people are by in large referred by parole officers to the other DOC employment programs. Community based job coaches assist individuals with honing their job search skills and obtaining job interviews.

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[6] Hagan, J., & Dinovitzer, R. (1999). Collateral consequences of imprisonment for children, communities, and prisoners. *Crime and Justice,* 121-162.

[7] Raphael, S. (2004, March). The socioeconomic status of black males: The increasing importance of incarceration. Retrieved January 1, 2008, from http://socrates.berkeley.edu/~raphael/the percent20socioeconomic percent20status percent20of percent20black percent20males percent20march2004.pdf

[8] Bonczar, T. (2003, August). *Prevalence of imprisonment in the U.S. population, 1974-2001*. Bureau of Justice Statistics Special Report. Washington DC: U.S. Department of Justice.

[9] Berlin, Gordon. 2008. *Poverty and philanthropy: Strategies for change*. MDRC. New York, NY.

[10] LaVigne, N., & Cowan, J. (2005). *Mapping prisoner reentry: An action research guidebook*. Washington, DC: Urban Institute.

11 Prison to Work: The Employment Dimensions of Prisoner Reentry, released by the Urban Institute Justice Policy Center, available: http://www.urban.org/UploadedPDF/411097_From_Prison_to_Work.pdf

[12] City of Chicago. (2006). *Rebuilding lives restoring hope strengthening communities: Breaking the cycle of incarceration and building brighter futures in Chicago.* Chicago: Author.

[13] Visher, C., & Farrell, J. (2005). *Chicago communities and prisoner reentry*. Washington, DC: Urban Institute.

[14] Prison to Home, The Dimensions of Prisoner Reentry, released by the Urban Institute Justice Policy Center, available: http://www.urban.org/UploadedPDF/from_prison_to_home.pdf

[15] The Criminal Correctional System section of this report describes the services at these two facilities in more detail.

Through its Office of Reentry Management, DOC has recently begun funding a Transitional Jobs (TJ) pilot program for parolees who are reentering Illinois communities from the state prison system. TJ is a workforce strategy designed to overcome employment obstacles by using time-limited, wage-paying jobs that combine real work, skill development, and supportive services, to transition participants successfully into the labor market. The program offers parolees transitional employment opportunities, training and support services through several contractors across the state.

Community agencies contracting with the state are an important part of the service delivery system. Research by Harry J. Holzer and others states finds that 60 percent of employers are reluctant to hire a person with a criminal record for a job.[16] However, Holzer also found that a third party intermediary, i.e. a provider agency in the community, significantly increases the chances that an employer will consider hiring a person with a record. Intermediary agencies and organizations are important because they maintain contact with the individual and provide ongoing support, encouragement and training. Also, agencies may take responsibility for drug testing, transportation, clothing, childcare and provide other resources that will remove barriers that interfere with an individual's ability to work.[17]

Funding: Funding for these programs totaled $8,316,600 in FY 10. Growth in prison and ex-offender populations means that demand for employment services far outstrips supply, at a time when the state itself is hard pressed to fund the spectrum of human services needs. A critical question for the immediate future therefore is not only the cost of funding these programs, but also the cost of not funding them. A recent Washington State Institute for Public Policy study found that each dollar spent on prevention saves upwards of 11 dollars in future incarceration costs.

Critical Issues and Trends: In Illinois and nationwide, a post-welfare-reform economy has substantially altered the type and quality of job opportunities available to those with limited work histories and incarceration's stigma: part-time, low-wage jobs with few or no benefits in industries that tend to churn through workers. Welfare reform as practiced in our state prioritizes funding job placement services ("Work First") over vocational training and skill building. As a result, low-skilled people with limited job experience are landing in equally insecure labor markets: a combination that makes it doubly hard to attach to the world of work.

"Tough on crime" policies and the War on Drugs have also changed the corrections landscape in Illinois and nationwide. Far more people are going to prison and then returning to their communities with a criminal record and diminished job prospects. Those with mental health and addiction issues have had little access to treatment.

Barriers to employment affect not only formerly incarcerated people but their families as well. Approximately 61 percent of incarcerated men polled in a study by the Urban Institute reported having at least one child under the age of 18, and 79 percent of those men provided financial support prior to prison. An inmate profile of female prisoners found that of the 82.5 percent of women with children, 80 percent were the head of single parent households prior to incarceration. Programs that help these

[16] How Willing Are Employers to Hire Ex-offenders, Holzer, Harry J., Raphael, Steven, Stoll, Michael A., Taken from three articles published by the authors: "How Do Crime and Incarceration Affect the Employment Prospects of Less-Educated Black Men?" paper prepared for the Extending Opportunities Conference, Washington, DC, 2002; "Perceived Criminality, Background Checks, and the Racial Hiring Practices of Employers," IRP Discussion Paper 1254-02, University of Wisconsin–Madison, 2002; and "Will Employers Hire Ex-Offenders?. Available at: http://www.irp.wisc.edu/publications/focus/pdfs/foc232h.pdf

[17] Re-Entry Policy Council Report, available at: http://reentrypolicy.org/

parents find employment thus indirectly affect the children and families that they provide for, as well as the formerly incarcerated people themselves.

Lately, the known and hidden costs of incarcerating large numbers of people are leading to reevaluations of criminal justice policy. Attention is shifting back to prevention and rehabilitation programs at a time when there is both growing need for it and limited funds. The Governor's Statewide Community Safety and Reentry Working Group, a joint effort between IDOC and IDHS developed a resource guide for people with criminal records available at ReentryIllinois.net. According to this resource, there are approximately 40 community-based programs across Illinois that exclusively focus on job readiness training and job placement for people with criminal records, with less than 15 of those programs being offered outside of the Chicago area. Such efforts recognize the importance of these services, though the demand for assistance continues to outweigh the available resources.

These programs recognize that while there will always be people in prison, 95 percent of them return to their communities. We know that ex-offenders who are employed are three times less likely to return to prison than those who are not.[18] In particular, enrollment into a Transitional Jobs program within 90 days of release from prison has a tremendous impact on reducing returns to prison, and increasing employment.[19,20] Programs that prepare prisoners and ex-offenders to find and keep jobs are therefore sound investments for challenging economic times.

People With Disabilities

Overview: In Illinois, 38 percent of working-age adults with disabilities are employed compared to 75 percent of working-age adults who do not have a disability.[21] Overall, 56 percent of people with disabilities are not working or looking for work, as compared to only 20 percent of individuals without a disability. The labor force participation rate (those working or looking for work) is also much less for people with disabilities: 44 versus 80 percent.

In light of these numbers, employment services for people with disabilities provide much-needed opportunities to achieve economic security as well as the health and social benefits of being connected to the world of work. The human services system in Illinois has a number of programs that address this need. Those overseen by the Illinois Department of Human Services' Division of Rehabilitation Services (DHS-DRS) are addressed in this section. However, it is helpful to understand the broader context of state and federally funded programs in which the DHS-DRS programs operate, including those that fall outside the scope of the Human Services Commission and this report.

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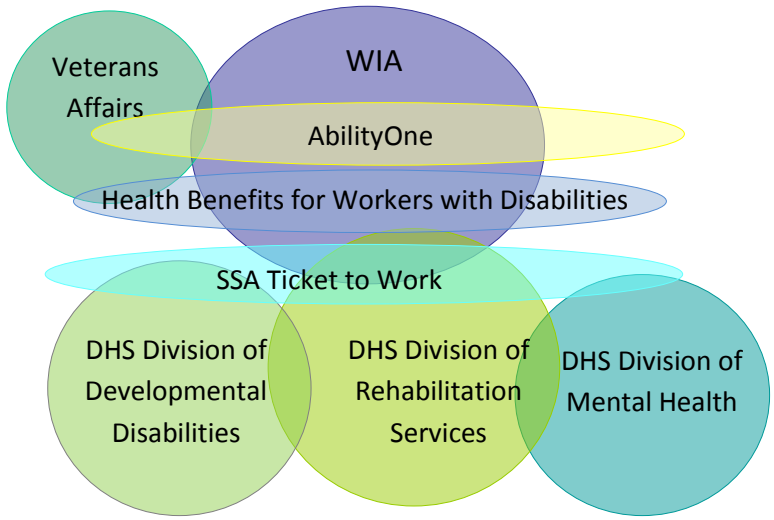
[18] City of Chicago, 2006. *Rebuilding lives restoring hope strengthening communities: Breaking the cycle of incarceration and building brighter futures in Chicago*

[19] Bloom, D. (2008). *Transitional Jobs for ex-prisoners: early impacts from a random assignment evaluation of the Center for Employment Opportunities (CEO) Prisoner Reentry Program*. New York: MDRC.

[20] Holzer, H. (2008). *Workforce development as an antipoverty strategy: What do we know? What should we do?* Bonn, Germany: Institute for the Study of Labor.

[21] US Bureau of Labor Statistics (BLS) has only been tracking employment statistics for people with disabilities since June 2008. The BLS estimates that the rate of unemployment for people with disabilities is seven to ten percent higher than the national rate (not adjusted for seasonal employment). In November 2009, the national unemployment rate for people with and without disabilities was estimated to be 16.9 and 9 percent, respectively. (That month, the unemployment rate in Illinois was 10 percent.) These figures include those recently unemployed and actively looking for work.



As illustrated in the above diagram, several state and federal programs and agencies in addition to DHS-DRS play a role in supporting employment for people with disabilities including:

- DHS Division of Developmental Disabilities: the range of services provided by DHS-DDD for people with developmental disabilities is covered in the Rehabilitative/Habilitative Services section of this report. DHS-DDD focuses predominantly on residential living arrangements, in-home supports, and day services such as day treatment and sheltered workshops. However, some funding is available for supported employment and vocational rehabilitation opportunities through a Medicaid waiver operated through DHS-DDD for home and community-based services.

- DHS Division of Mental Health: DHS-DMH provides a continuum of services for people with mental illness, which are covered in the Mental Health section of this report. Recognizing and that employment can play an integral role in a person's rehabilitation, DHS-DMH's psychiatric rehabilitative services include employment-related services. Federal Medicaid law prohibits direct funding for vocational and employment training; however, under the federal Medicaid Rehabilitation Option, mental health providers may deliver services anywhere in the community, including job sites. Because the line between a "mental health service" and an "employment service" for an individual with mental illness is not distinct, some Medicaid reimbursement is possible. For example, mental health providers can bill Medicaid for services that help someone deal with the symptoms of their illness as they try to do work activities, as well as assist them in the activities that will enable them to get to and stay at work. To provide fee-for-service employment services, DHS-DMH contracts with community mental health centers and community-based provider agencies. Individuals access this system through referrals from doctors, hospitals, and family members.

- Illinois Department of Veterans' Affairs: The Illinois DVA is charged with coordinating state-based services and supports to wrap around returning military services members. These services include access to employment services and supports.

- Social Security Administration Ticket to Work Program: In 1999, Congress enacted the Ticket to Work and Work Incentives Improvement Act (TWWIIA) to increase the rehabilitation options available to Social Security Disability beneficiaries who want to work inside and outside of state VR systems. Under this system, entities called Employment Networks (ENs) are funded based on performance standards, including entry of Social Security Disability beneficiaries into employment and the achievement of subsequent milestones over a five-year period. Employment Networks are individual community rehabilitation providers, private companies, state entities, or partnerships between such organizations and agencies, and are approved by the SSA. Employment Network services under the Ticket to Work Program are available to all Social Security Disability Insurance and Supplemental Security Income beneficiaries in current cash status. There are no requirements as to what services or supports must be provided to beneficiaries through Employment Networks. The individual and the provider work together to create a plan for employment, called the Individual Work Plan, which describes exactly what the individual will do to reach a specific employment goal and what the provider will do to assist and support the individual.

- Workforce Investment Act (WIA): WIA programs support a range of people in finding and maintaining employment, including individuals with disabilities. WIA programs are largely federally funded and in Illinois are administered primarily through DCEO, which is described in Appendix E.

- AbilityOne: AbilityOne is a federal program that provides employment opportunities for people who are blind or have other severe disabilities in the manufacture and delivery of products and services to the federal government. Currently there are 72 active AbilityOne projects in Illinois, employing 1,393 people with disabilities. People are hired mainly through contracts with nonprofit agencies to provide services including grounds maintenance, mail delivery, administration, and food service.

- Health Benefits for Workers with Disabilities (HBWD): HBWD is a health care program for working people with disabilities, administered by the Illinois Department of Healthcare and Family Services. People who meet or equal a federal disability standard can pay a premium to participate in the state's Medicaid program and access the state's waiver services like the Home Services Program. An individual must be working and paying FICA in order to qualify. Income eligibility is at 350 percent of the federal poverty level (FPL) and assets are set at $25,000 (retirement accounts are exempt from asset eligibility).

Populations served: Employment services of DHS-DRS target working-age adults (16 to 64 years of age) with significant physical or mental impairment that results in a substantial impediment to employment are eligible for Vocational Rehabilitation (VR) employment services. Eligibility criteria vary between programs, and are often tied to the federal funding stream, which makes it difficult for people to access all of the supports they need.[22] The majority of individuals accessing VR employment services live in

[22] In its review of this report, Access Living notes that "since 2004, DRS has used a screening process called the 'order of selection,' which requires consideration of the number of functional limitations resulting from disability as part of the eligibility

Chicago or the collar counties, are women over the age of 30 and have had their disabling condition for at least five years.

Currently, there is no waiting list for VR services, which served more than 44,000 persons in FY 09. Included in this total are 4,804 individuals with significant disabilities to whom DRS provided competitive employment in FY 09. The average wage was $10.02/hour in FY 09. This statistic has increased significantly over the past five to six years, as the average wage was $8.36/hour in FY 03. Also, DRS provided services to 386 individuals with disabilities who went to work at a substantial gainful activity level in the past year. The monies recouped from the Social Security Administration (SSA) for reimbursement of these services was higher than any state in the region, with the exception of Ohio ($4.42 million in the past federal fiscal year).

Additionally, DHS-DRS provides transition services to all eligible students with disabilities through the Secondary Transitional Experience Program (STEP). Last year 15,728 individuals received services through STEP, with an additional 3,197 transition age youth served through DRS local offices. In FY 09, DRS had 155 STEP contracts with approximately 600 high schools in the state.

When demand for services exceeds available resources, federal law requires that DRS serve people with the most severe disabilities first. Looking ahead, we will likely see growth in demand for VR (and other services for people with disabilities) for two reasons.[23] First, it is always challenging for people with disabilities to find work; it is harder still in today's recessionary economy.[24] Second, Illinois has one of the largest National Guard populations overseas, many of whom are returning from duty with significant physical and psychiatric disabilities that will require state-funded VR and other services.

Service Delivery System: DHS-DRS employs rehabilitation counselors, coordinators, and other VR professionals in 48 offices throughout the state to provide direct services to VR customers. DHS-DRS counselors determine eligibility, work with customers to establish vocational goals and develop an Individualized Plan for Employment (IPE) to carry out the appropriate array of services. Most common DRS services include evaluation, training, educational assistance, placement, and follow-up supports such as on-the-job coaching. In some cases, DHS-DRS provides physical or occupational therapy and other medical services. Its Supported Employment Program provides competitive work in an integrated work setting for individuals with severe disabilities who have not worked, or have worked intermittently, in competitive employment, and need ongoing support services. These services and supports focus on preparing individuals for employment with monthly wages set by SSA's Substantial Gainful Activity level: $1000 for non-blind individuals and$1640 for blind individuals in 2010.

While DRS receives targeted dollars from the US Department of Education's Rehabilitation Services Administration for Supported Employment services, the majority of these services for people with

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for services. Those with more severe disabilities qualify because they have more functional limitations, but those who experience fewer functional limitations due to their disability are less likely to qualify. Hence, DRS does not serve every Illinoisan with a disability who may be in need of its services. JCAHO Administrative Code Title 89, Chapter IV: DHS, Subchapter b: Vocational Rehabilitation, Part 553 Assessment for Determining Eligibility and Rehabilitation Needs, Section 553.140 Criteria for Most Significant Disability and Very Significant Disability and Significant Disability."

[23] "Illinois disability applicants have long wait for benefits," Monifa Thomas, *Chicago Sun Times*, April 13, 2010. Available at: http://www.suntimes.com/lifestyles/2154962,CST-NWS-health13.article

[24] *Income at Risk: Unemployment Continues to Plague Those with Disabilities, Reports Allsup*, Businesswire, April 20, 2010. Available at: http://insurancenewsnet.com/article.aspx?id=181384

developmental disabilities and mental health issues is paid for through Medicaid state plan and waiver programs. Medicaid pays for a significant portion of employment services for people with disabilities.

Since VR is the main entry point to the employment services systems for individuals with disabilities, those who do not opt for VR or receive services through other systems such as DDD or DMH are often unaware of other mainstream employment services that promote self sufficiency. However, DHS-DRS, DHS-DDD and DHS-DMH do collaborate with DCEO's WorkNet centers so that customers can access additional employment or wrap-around services, many of them provided by contracted community based providers. DRS has Memoranda of Understanding with all mandated WIA partners, is an active participant in all workforce areas in Illinois and is fully included at the one-stop centers in Mt. Vernon, East St. Louis, and Champaign.

Funding: Funding for DHS-DRS employed programs totaled $133,428,448 in FY 10, of which $118,202,600 came from the federal government. This reflects how the employment system for people with disabilities operates overall: it is largely funded by federal programs that flow to various state agencies. The federal agencies involved include the U.S. Departments of Labor, Veteran's Affairs, Health and Human Services, Education and the SSA. DHS-DRS also has state funds that are matched by a federal grant from the Rehabilitation Services Administration.

Critical Issues and Trends: Illinois' current fiscal crisis, while certainly challenging, provides an opening for a discussion about how services and supports for people with disabilities can be delivered smarter and better in difficult times.

Currently, as previously outlined above, the employment service system for people with disabilities in Illinois is a conglomeration of agencies each with its own eligibility criteria, funding streams and focus.[25] This, as well as the equally diverse requirements of various federal agencies that provide the bulk of dollars, means that the system is not well integrated. The customer in need of services does not stand at the center of such a system; rather he or she must negotiate and move around it, in order to find all needed supports. State agencies and the policy and advocacy community agree that employment should be the expected outcome for people with disabilities, but all are struggling with how to identify policies and programs can best be coordinated to achieve this goal.

Given these challenges, it is encouraging to know that Illinois has one of the best health care programs for workers with disabilities in the country: Health Benefits for Workers with Disabilities (HBWD), administered by the Illinois Department of Healthcare and Family Services. Few community-based service providers and even fewer individuals even know about it. Since fear of losing one's healthcare benefits is one of the leading barriers to workforce participation, this program merits notice.

Similarly, people with disabilities in Illinois do not utilize SSA work incentive programs, such as Ticket To Work, to the same extent as their counterparts in similar size states (such as Ohio and Pennsylvania).[26]

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[25] DHS-DRS prioritizes the most severely disabled. Illinois WorkNet centers offer various programs, each with differing eligibility criteria. The DHS-DDD and DHS-DMH both have Medicaid waiver programs that provide supported employment services. Health-related employment supports include the DHFS's Health Benefits for Workers with Disabilities. Personal Care Assistance, administered by DRS, the Home Services Program and various DDD and DMH programs all have differing eligibility criteria.

[26] SSA's Ticket Tracker, available at http://www.yourtickettowork.com/offsite?back_url= percent2Fprogram_info percent3Fselect percent3Dwhere-when&href=http percent3A percent2F percent2Fwww.socialsecurity.gov percent2Fwork

While the reasons for this are not completely clear, this indicates that the provider community may not be adequately pointing people to these programs and supports.

SENIORS

Overview: Older people who are unemployed but capable of working face challenges that include obsolete skills, limited job opportunities and age discrimination that is hard to perceive or prove (age discrimination laws tend to more effectively protect the already employed). It is estimated that older job seekers are unemployed for one and one-half times longer than their non-elderly counterparts.

Through the Department on Aging (DOA) and with federal support, Illinois offers several programs to address these barriers. The largest of these is the Older Americans Act (OAA) Title V Senior Community Service Employment Program (SCSEP). SCSEP places seniors into time-limited jobs that benefit the older adult participants, the community agencies and organizations that host them and the larger community these entities serve.

Engagement of older persons into community life has benefits for the health of both the older person and the community. Volunteer opportunities are essential for channeling energy, experience, knowledge and to provide needed services for the community. The Retired and Senior Volunteer Program (RSVP), part of the Corporation for National and Community Service Senior Corps program, recruits, trains and deploys nearly 15,000 volunteers who provide over 2.8 million volunteer hours annually to hundreds of community organizations throughout the state.

Populations served: RSVP provides volunteer opportunities for age 55 and over citizens. SCSEP participants must by 55 or older. They tend to be under the age of 65 and female. Income eligibility is set at 125 percent of the FPL, currently, for a one-person household, $13,538 or less a year. Most receive some form of public assistance such as SNAP, Social Security, General Assistance or a housing subsidy.

DOA administers 416 of the 2,251 slots assigned to Illinois by the US Department of Labor (DOL; the rest of the Illinois slots are tied to national contractors and do not go through the state's budget). DOA administers another 88 slots (of 486 total for Illinois; again with the balance handled by national contractors) have been funded by ARRA (stimulus funds). The ARRA grant period began March 17, 2009 and will end on June 30, 2010. DOA does not have information on the total number of additional appropriations slot for national contractors, but did receive 148 slots.[27]

Service Delivery System: DOA receives funding for the state's SCSEP program, while as already noted, national organizations – in Illinois there are seven – operate programs through direct contracts with the DOL. The number of slots given to each host-agency (sub-grantee) depends on their size and the number of potential job seekers in their area. The Senior Employment Specialist Program (SESP) provides additional funding to support staff time to coordinate the program.

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percent2Faboutticket.html, reports that as of May 13, 2010, 428,127 tickets had been issued through Illinois' Ticket to Work program, compared to 468,731 in Ohio and 559,660 in Pennsylvania.

[27] If the program funding under the regular program and ARRA are correct indicators, national contractors could have another 500 slots under the Additional Appropriations funding program.

Per DOL requirements, host agencies for SCSEP are nonprofit and government agencies of all sizes. On-the-job training assignments are for up to 20 hours per week and pay the current state minimum wage ($8 per hour in Illinois). At their job sites, participants develop skills, such as computer software and data entry, that help them with their job search.

Under the current program structure, unemployment benefits for SCSEP participants decrease in tandem with wages. This disincentive is a departure from other DOL programs, one that keeps some away from this program.

As can be imagined, there are on-going coordination issues between the DOL direct-funded national contractor programs and the state program. At times this sets agencies in competition for slots. Coordination plans exist, but DOL does not always provide current information and support for them.

RSVP is operated by 23 organizations throughout Illinois. The sponsoring organizations provide community resources to match the federal funding, develop volunteer opportunities, recruit participants, refer individuals to appropriate activities and sustain a volunteer corps with recognition and social activities.

Funding: As noted above, in FY 10, SCSEP was funded in three separate allotments which for Illinois translated into three appropriations: the regular program (416 slots), ARRA (88 slots), and new (148 slots). This was a significant expansion and responsive to the needs for older adults during the recession. Some of these funds, however, are temporary and without additional dollars Illinois will lose slots before real economic recovery takes hold. FY 11 will roll back SCSEP funds by eliminating ARRA funding as of June 30, 2010 and will reduce by 50 percent the new Title V funding that was effective in January of 2010.

An additional GRF grant was provided, through SESP, to agencies to work with older persons not eligible for SCSEP. It received a 10 percent cut in funding from FY 09 to FY 10.

Critical Issues and Trends: In past recessions, older workers tended to exit the workforce and retire. The current recession is different. Many older people need to keep working. SCSEP's value, therefore, is that it helps older adults be part of the workforce while they search for longer lasting employment. As job seekers of all ages can attest, the best way to find your next job is to already have one.

Structured volunteer opportunities such as those provided through RSVP help ensure quality of life for older persons and community organizations. When considering the needs of older persons, civic engagement is a key theme.

SCSEP is funded under Title V of the OAA. Since its reauthorization in 2000, we have seen more emphasis on the placement side of the program. In the past, community service and income supplement aspects of SCSEP were equally valued. Today, however, DOL aims to bring SCSEP in line with other job training programs, with a focus on the common measures used to evaluate.

Finally, it should also be noted that the federal share of these programs requires a state or local match. DOA funding does not entirely meet the federal match requirement, which leaves local agencies to cover the remaining share. Increasingly, many cannot, due to the poor economy. Instead, they choose to receive less funding and operate a smaller program. Some may choose to stop their local program in its entirety.

Human Service Category: Employment

Data Source: State agencies as indicated in the first column

Employment for Seniors

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DOA	Title V Employment	Provides training and part-time employment opportunities for low-income older workers. These federal funds are from the U.S. Department of Labor.	Promotes community service and unsubsidized employment for older workers.	$4,500,000
DOA	ARRA Employment Title V	Provides additional federal funding for training and part-time employment opportunities for low-income older workers.	Promotes community service and unsubsidized employment for older workers.	$950,000
DOA	RSVP	Provides matching funds for federal grant awards from the Corporation for National and Community Service to 23 providers.	Provides individuals age 55 and older with volunteer opportunities to use their skills and experience to meet critical community needs.	$703,800
DOA	Senior Employment	Provides funding to Area Agencies on Aging to hire staff to promote senior employment opportunities and to support administrative activities for the federal grant from the U.S. Department of Labor (SCSEP).	Employment referrals for older workers; employer education	$237,900
DOA	Additional Title V Employment	Provides training and part-time employment opportunities for low-income older workers. These funds are additional funds received from the U.S. Department of Labor to IDoA.	Promotes community service and unsubsidized employment for older workers.	$0

Employment for Ex-Offenders

DOC	Job Preparation	To provide offenders with job skills, interview skills, a resume, computer abilities, and an understanding of the work ethic.	Employment	$5,785,600
DOC	Transitional Jobs	Providing real-world work experience for releases.	Independent living	$1,771,000
DOC	Delancey Street Program	To provide job training for offenders in various trades by tradesmen.	Independent living	$760,000

Employment for People with Disabilities

DHS-DRS	Vocational Rehabilitation	This program supports a wide range of services designed to help individuals with disabilities prepare for and engage in gainful employment consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. Funds are administered under an approved state plan by VR agencies designated by each state. The state-matching requirement is 21.3 percent.	• Job Placement • On-the-Job Training and Evaluations • College and University Training • Treatment and Restoration Services • Supported Employment • Assistive Technology	$127,802,200
DHS-DRS	Small Business Enterprise Program	Provides persons who are blind with remunerative employment and self-support through the operation of vending facilities on federal and other property.	Provides employment opportunities for trained, licensed blind persons to operate facilities within the state.	$3,527,300
DHS-DRS	Extended Services	Provides services necessary to maintain individuals in employment after the end of supported employment services.	Extended services allow individuals with significant disabilities to maintain long term employment. These extended support services can only be used if services are required beyond the federally funded 18 months of supportive services.	$1,054,600
DHS-DRS	Supported Employment	Assists in developing and implementing collaborative programs with appropriate entities to provide programs of supported employment services for individuals with the most significant disabilities who require supported employment services to achieve employment outcomes.	Supplement funds for the costs of providing supported employment services. These funds can only be used to provide intensive training for the first 18 months to achieve stability.	$1,044,348

DHS-DRS	Migrant Services	Provide vocational rehabilitation services for migrant and seasonal farm workers with the most significant disabilities and a wide range of human services to address the needs of family members who reside with them.	Provide fully accessible, culturally appropriate services to migrant and seasonal farm workers with disabilities and their families, enhancing the quality of their lives and assisting them in moving towards becoming self-sufficient. Services include vocational evaluation, counseling, mental and physical restoration, vocational training, work adjustment, job placement, and post employment services.	$701,924

SNAP and TANF Employment and Training and Other Employment

DHS-HCD	TANF Job Placement Work First Transitional Jobs TANF Special Projects	Employment and Training services for Temporary Assistance for Needy Families (TANF) and other low income TANF eligible customers to assist them addressing their barriers and with developing job skills necessary for obtaining employment and becoming self sufficient. TANF Job Placement – Customers are assigned to work and training activities in order to gain job skills and be placed into unsubsidized employment. Work First – Pay after performance program where the customer earns their TANF assistance grant through participation in the Work First program and assigned activities. Transitional Jobs provides intensive case management, wrap around services and unsubsidized employment placements to assist customers in gaining unsubsidized employment and achieve a higher level of self-sufficiency. TANF Special Projects – individually negotiated services to address specific barriers and/or employability needs for customers.	Customers will obtain unsubsidized employment and meet job retention of 30, 60, 90 and/or 120 days on the job. TANF Job Placement – serve 1,136 customers and place 566 in unsubsidized jobs with retention. Work First – serve 1,376 customers and place 688 in unsubsidized jobs with retention. Transitional Jobs – serve 143 customers and place 121 in unsubsidized employment with retention.	$19,313,950

DHS-HCD	SNAP Employment and Training Programs: Earnfare Non-Custodial Parent Earnfare SNAP E&T Job Placement SNAP E&T Special Projects	SNAP Employment & Training Programs offer eligible participants an opportunity to gain job skills, work experience and under the Earnfare component, earn financial assistance. Participation is limited to adults who receive non-assistance food stamps and who volunteer.	Gain job skills and work experience. Customers will obtain unsubsidized employment and meet job retention of 30 days on the job. Earnfare – serve 7,732 customers in Earnfare assignments annually. Non-Custodial Parent Earnfare – serve 60 customers in court ordered Earnfare assignments. SNAP E&T Job Placement – serve 2,871 and place 1,455 in unsubsidized jobs with retention. SNAP E&T Special Projects – serve 66 customers and place 44 in unsubsidized jobs with retention.	$9,945,318
DHS-CHP	AmeriCorps	AmeriCorps is a national service program that involves "getting things done" in communities. AmeriCorps members develop an ethic of service while strengthening local communities.	Community Sustainability	$10,254,980

FOOD AND NUTRITION

Overview

Access to food is one of the most basic human needs. There are many known links between hunger and poor health and human development:

- Hunger negatively affects the attention span and academic performance of children[1]
- Children who are unequipped to learn because of hunger are more likely to be poor as adults[2]
- Hungry children suffer from two to four times as many health problems, such as unwanted weight loss, fatigue, headaches, irritability, inability to concentrate and frequent colds[3]
- For many people, medication cannot have its intended effect without the proper nutrition to accompany it[4]
- Among the elderly, malnutrition exacerbates diseases, decreases resistance to infection and extends hospital stays[5]

Adequate food and nutrition allow children and adults to be healthy and able to learn, work and reach their full potential.

Hunger's scope, effects and our response to it all are changing. Historically feeding programs focused on severe hunger and starvation. As such the emphasis was on calories delivered more than nutrition or food quality. Today, there is growing recognition that obesity and its health consequences are connected to hunger and to the limited food options of low-income households. In fact, communities with high rates of food insecurity often have a high rate of obesity as well. For example, a recent survey conducted by the Food Research and Action Center (FRAC) found that the 4th Congressional District in Illinois had one of the highest rates of food hardship in the U.S.[6] Neighborhoods within this district have been identified as having high rates of obesity as well[7].

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[1] *Food Insufficiency and American School-Aged Children's Cognitive, Academic, and Psychosocial Development*, K. Alaimo, Olson and Frongillo, *Pediatrics*, Vol. 108, Issue 1, July 2001.
[2] *Child Food Insecurity: The Economic Impact on Our Nation*. J. Cook. July 2009. Available at http://www.childrenshealthwatch.org/upload/resource/FA_Report_july2009_full.pdf.
[3] *Health Consequences of Hunger*, Food Research and Action Center (FRAC). Available at http://www.frac.org/html/hunger_in_the_us/health.html.
[4] *The Power of Nutrition*, Association of Nutrition Services Agencies, available at http://www.ansanutrition.org/userfiles/file/The percent20Power percent20of percent20Nutrition.pdf.
[5] Lee, Jung Sun & Frongillo Jr., Edward A. (2001) Nutritional and Health Consequences Associated with Food Insecurity among U.S. Elderly, *The Journal of Nutrition,* 131: 1503-1509.
[6] *Food Hardship: A Closer Look at Hunger*, FRAC, January 2010. Available at http://www.frac.org/pdf/food_hardship_report_2010.pdf.
[7] *Sinai Health System's Community Health Survey: Report 1*, Whitman S, Williams C, Shah A., (Chicago, IL: Sinai Health System), 2004. Available at http://www.suhichicago.org/files/publications/P.pdf.

Responses to hunger, therefore, are increasingly focused on the need for quality, nutritious food, including fresh fruits and vegetables. There is also recognition that food and nutrition assistance is a kind of income support, one that helps low-income households extend limited resources to other fundamental needs: housing, utilities, medical costs. And there is growing recognition that hunger relief is about more than pounds of food delivered. It can play a part in public health and anti-poverty strategies. This more expansive approach is leading some in this field to explore new delivery systems, partnerships and collaborations.

In Illinois, three state agencies oversee 17 programs that address the food and nutrition needs of children and adults, including senior citizens: the Illinois Department on Aging (DOA), the Illinois Department of Human Services (DHS) and the Illinois State Board of Education (ISBE). Nutrition programs are largely federally funded, with some direct state investment. In FY 10, funding for these combined programs totaled nearly $3.4 billion, the majority of which – 69 percent – was devoted to SNAP (the Supplemental Nutrition Assistance Program, formerly food stamps).

Populations Served

People who need food services span all ages and household compositions. The largest program that serves them, the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) is available to any qualifying low-income individual or household.[8] Other programs target specific vulnerable populations such as pregnant women, children or older adults. For these, eligibility criteria vary by program. Except for some programs serving seniors that are not means-tested, most are dependent on income (ranging from 100 – 185 percent of the federal poverty level [FPL] – see Appendix G for an illustrative table) as well as household size, age and / or citizenship status. For food and nutrition programs under the Older Americans Act (OAA), clients who have meals delivered to their home receive an assessment. Under the OAA, participation cannot be limited based on a means test (participant contributions are encouraged and are made).

Millions of people in Illinois are served by these programs, as shown in these key service statistics:

- SNAP: As of December 2009, 1,624,175 individuals in Illinois received nutrition benefits. In FY 09, the average monthly benefit per household in Illinois was $285.85.
- School Breakfast and Lunch: In FY 10, an estimated 992,977 children in Illinois were eligible for free or reduced priced meals, according to the Illinois State Board of Education's (ISBE) web site.
- WIC (Special Supplemental Food Program for Women, Infants and Children): 309,870 pregnant women and children were served during FY 09, according to March 2010 data from the USDA.
- Commodity Supplemental Food Program: Nearly 14,000 people, mostly older adults, were served in FY 09 and this number should increase slightly in FY 10.
- Older Adult Programs: For federal FY 10, DOA projected that 70,350 persons will receive congregate lunches and 43,253 will receive home-delivered meal.

[8] See the Employment section of this report for information on work-related activities that, for some, are a condition of receiving food assistance benefits.

- Emergency & Supplemental Food / TEFAP (The Emergency Food Assistance Program): More than 1.4 million Illinoisans are served by community food banks annually and the food distributed by food banks includes both TEAFP commodities and privately donated food.

When reviewing these numbers, it is important to note the gap between those served and those not served by these programs. There are many more families and individuals who are eligible and in need of assistance, even if it is hard to quantify those not enrolled in programs. Data collected prior to the current recession suggest that over 250,000 households in Illinois are eligible for SNAP benefits but not receiving them, a figure that has likely climbed under the poor economy.[9] Remedies for low enrollment include the use of cross-program certifications. Direct certification[10] can help families and individuals become aware of available resources and able to access them. School breakfast is an integral part of the educational day and continued expansion of alternative serving locations, such as the classroom, is seen as a way to increase participation rates in Illinois and help leverage additional federal funds.

Service Delivery System

Hunger relief efforts in Illinois are carried out by a mix of government agencies, community-based organizations and for-profit entities, acting alone and in collaboration with one other. Programs such as SNAP and WIC are provided through various government offices in the state. School-based meals are provided through public and private schools. Additionally, there are nearly 2,000 food pantries, soup kitchens and shelters that provide emergency and supplemental food services throughout Illinois.

At the federal level, the government agencies that regulate and fund food and nutrition programs are the Departments of Agriculture (USDA) and Health and Human Services (HHS), at the state, DHS, DOA and ISBE are the lead agencies. Often, these government agencies contract with community-based organizations that deliver food and services. For example, Area Agencies on Aging (AAA) contract or provide grants to nutrition programs, with the City of Chicago providing nutrition services directly in partnership with community host sites.

The Nutrition Programs Division of the Illinois State Board of Education (ISBE) is responsible for the administration of the USDA Commodity Food Distribution Program. This supplemental program annually provides approximately $40 million worth of commodity food to over 1,100 school districts in Illinois. Active participation in the National School Lunch Program is the primary criteria to be eligible to receive USDA commodity food.

In addition to federal and state-funded nutrition programs, there are also many private efforts aimed at combating hunger and providing quality, nutritious foods for individuals and families in our state. These include programs run by charitable organizations such as food banks, food pantries and soup kitchens.

[9] *Reaching Those in Need: State Supplemental Nutrition Assistance Program Rates in 2007*. Mathematica Policy Research Center, November 2009.

[10] Direct certification is a provision of the National School Lunch Act that allows school districts to automatically qualify children receiving TANF or SNAP benefits for free meals without requiring individual applications.

Although these organizations distribute food provided by government programs, many other goods and the services these nonprofits offer are made possible through support from individuals, corporations, foundations, and food donors throughout the community.

Food and nutrition services and the methods by which they are delivered take many forms. They can be provided as a monetary benefit, allowing people to purchase food directly. This is the case with two of the largest programs, SNAP and WIC, as well as the smaller Farmer's Market Voucher Programs. For these, benefits are loaded onto an EBT (Electronic Benefits Transfer) card or provided as a voucher. These are then used to purchase approved food items at retail outlets or approved food centers.

Applications for SNAP benefits are processed through DHS Family Community Resource Centers (FCRCs). Adequate staffing levels at these offices is a significant concern, as is the technology and infrastructure needed to process applications in a timely manner and provide households with the attention they need. Staffing levels were already low prior to the recession: Participation in all DHS Human Capitol Development (HCD) programs grew from approximately 851,000 in 2001 to 1,215,000 in 2005.[11] During the same period, frontline HCD staff was cut from 4,000 to 2,743. The average worker caseload grew from 288 in 2001 to 636 in 2009.[12]

Another primary branch of the service delivery system is the "congregate meal setting." This includes school-based, afterschool, and summer meals for children, meal programs at senior citizen centers and meals provided through shelters and soup kitchens. Food is also provided as groceries from food banks and pantries, food packages and ready-to-eat meals that are then taken home, and / or prepared and delivered by volunteers or paid staff to homebound people.

For seniors, OAA-funded congregate meal programs have been an important part of rural service programs; however, the aging of that group has led to a decline in the number of participants. Meanwhile, demand for home delivered meals has seen a steady increase over the past 10 years. In FY 99, 6.5 million meals were served. This grew to 7.8 million in FY 09. The OAA requires that meals meet one-third of the Required Dietary Intake (RDI) and emphasizes high-fiber foods, including fruits and vegetables as well as healthier preparation methods. These are not always well-received by older persons, so the change to the new menu has affected both food cost and receptivity.

It is important to note that there are unique challenges of food access and distribution in rural parts of our state. Many low-income families in these areas are 50 or more miles away from the nearest grocery store, FCRC or even a private food assistance agency. Mobile pantries are one solution to this barrier, as they can cover multiple areas of the state where agencies and offices may not exist.

Funding

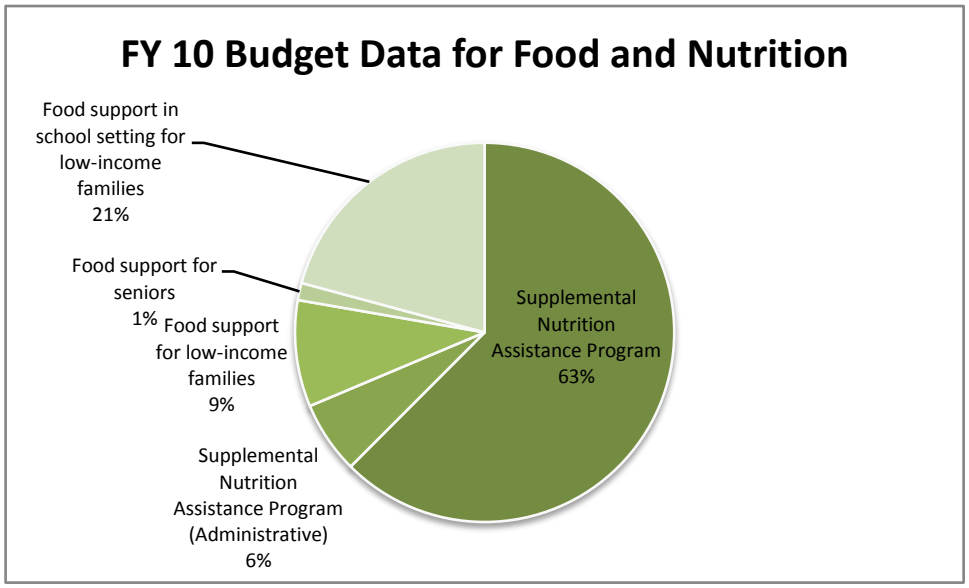
FY 10 budget data on food and nutrition programs provided by DHS, DOA and ISBE reveal the following distribution of funding:

[11] Growth in the non-grant SNAP caseload accounted for much of this increase.
[12] Sources: DHS case count data, and AFSCME.

FY 10 Budget Data for Food and Nutrition

	Total
Total	$3,390,804,871
Supplemental Nutrition Assistance Program	$2,118,901,101
Supplemental Nutrition Assistance Program (Administrative)	$209,015,693
Food support for low-income families	$307,923,577
Food support for seniors	$49,645,400
Food support for children in low-income families	$705,319,100

The $3.4 billion budgeted in FY 10 for food and nutrition programs is visually illustrated below:[13]



Food and nutrition programs in Illinois are largely federally funded, with the exception of DOA's Home Delivered Meal program, which receives about half of its funding from General Revenue Funds (GRF).

In FY 09 and FY 10, stimulus funds (American Recovery and Reinvestment Act, ARRA) brought additional dollars to some nutrition programs. There was a 13.6 percent increase in benefit levels for SNAP in all states; $6.2 million in additional funding through TEFAP; as well as $3.6 million for infrastructure

[13] Administrative costs for SNAP are broken out from the benefit cost for the program as these two aspects are funded differently. SNAP benefits are 100 percent federal funding, whereas the administrative costs are split 50/50 between state and federal funds.

improvements and equipment purchases to provide school meals.[14] OAA Congregate and Home Delivered Meals received increased funding through ARRA with an additional $3.5 million for Illinois for a 15-month period that will end on September 30th of this year. Sixty-six percent of these funds were allocated to congregate meals and 34 percent to home delivered that will end on September 30, 2010.

For SNAP, there have also been significant additional administrative funds for Illinois: $12.1 million under ARRA for FY 10 and $16.6 million in the FY 11 appropriation. Only about 25 percent of the new money was allocated to increasing staffing levels in FY 10. Advocates have requested that DHS make staffing levels more of a priority in federal spending plans for FY 11. However, all of this additional federal funding will be largely phased out by the end of FY 11. There were also significant increases to nutrition programs such as SNAP and TEFAP in the 2008 Farm Bill and, in the case of TEFAP, mandatory spending for this program will be adjusted annually for inflation.

For other programs, including those serving older adults, federal funding has not kept pace with growth in need. Due to a phase out of a guaranteed growth provision in the Administration on Aging (AOA) interstate funding formula for OAA programs, Illinois is not expected to receive any of the modest increases for OAA nutrition services for FY 11.

Many nutrition programs have mandatory or entitlement funding. In other words, the federal contribution is determined by program participation levels. This means that Illinois could draw millions more in federal funds each year if it increased participation in nutrition programs. Illinois currently ranks low among other states in enrollment for free and reduced-priced school breakfasts. It is estimated that increasing participation in Illinois' School Breakfast Program to 60 percent from the current 34 percent would yield an additional $44,492,903 in federal funds and would result in 191,678 more children receiving breakfast every day.[15]

Illinois currently provides $361,800 in state funds to increase school breakfast participation. These funds are disseminated through competitive grants of $3,500 for schools to start a School Breakfast Program as well as through an automatic reimbursement of an additional $0.10 for each breakfast served over the amount served in the same month of the previous year.

Looking ahead, as already noted, funding for mandatory and entitlement programs such as SNAP will be based on participation levels. For discretionary programs, the FY 11 federal budget has not yet been finalized but funding is expected to remain flat with the exception of a few small program increases. There is a possibility that funding for some child nutrition programs will be increased in FY 11 as part of the Child Nutrition Reauthorization. The OAA is due for reauthorization in 2011. Federal funding for seniors will not increase before then unless significant additional dollars are appropriated by Congress to make up for the restrictions in AOA's interstate funding formula which moves new funds to states with significant growth in their senior populations. The Farm Bill was reauthorized in 2008 and will be up again for reauthorization in 2012.

While the current state budget crisis is not having a significant direct impact on the funding for most nutrition programs (due to the fact that they are primarily federally funded), state budget cuts in other

[14] Illinois-specific data were taken from the Notice of Award letters posted on http://recovery.illinois.gov .
[15] *School Breakfast Scorecard: 2008-2009 School Year*, FRAC, December 2009. Available at http://www.frac.org/pdf/breakfast09.pdf

areas could have a significant impact on program delivery. For example, if funding for afterschool programs is cut or eliminated, this could affect the number of afterschool meals provided to children.

Critical Issues and Trends

Parallels have been drawn between the current economic crisis and the Great Depression. A question we hear often is, "Will we see soup lines like we did in the 1930s?" The reality is that in some communities, the lines of people waiting for food outside pantries and soup kitchens have been long for years.

Yet, there are important differences between the Great Depression and today. With a network of private and public programs serving millions of Illinois residents each year, hunger is less a story of starvation and more one of hunger's health and economic consequences.

Often these consequences can be traced to availability, access and affordability. High-calorie, low-nutrition foods that are high in fat and sodium are often less expensive – and therefore more available – than grains, produce and dairy products. As a result, many low-income individuals and families simply are not getting enough nutritious food. Today we are seeing a rise in the number of low-income people of all ages who are overweight and suffering from related health issues that pose a whole new set of costs on the human service system. Going forward, we may see obesity, food disorders, diabetes and other lifestyle-affected health issues reverse the life expectancy of future generations. Food and nutrition programs that deliver healthy foods as well as information and educational to support behavior change, are key to reducing healthcare costs that burden our state.

Today, a lack of access to quality food retailers and affordable fresh fruits and vegetables is a significant issue facing Illinois' human services system. Schools and other meal providers report that it is difficult to provide quality, fresh food to the people they feed due to the higher cost of produce and insufficient reimbursement rates. Pantries, food banks and congregate meal programs are also limited by transportation or other logistical barriers.

Cost and affordability issues return us to the point that most nutrition programs are largely federally funded. It is important to note that the aforementioned pieces of federal legislation – the Farm Bill, the Child Nutrition Act and OAA – are either currently undergoing reauthorization or will soon. Each reauthorization process is an opportunity to improve access to and the scope of food and nutrition programs, and to reduce administrative barriers faced by customers and the organizations that administer these programs.

Increasing the number of eligible households that receive SNAP benefits would increase the flow of federal dollars to Illinois, where they will turn over in the communities where food is purchased. With the advent of "no wrong door" approaches to human services delivery, this affects other programs including Medicaid and TANF. Therefore, one of the underlying issues that remains is the reduction in staffing levels that FCRCs have experienced in recent years, at the same time that more households are requesting assistance. Staffing cuts to the SNAP program and other DHS Human Capitol Development programs – with only small amounts of temporary federal funding identified to address the problem – had made timely processing of applications a challenge.

There is an opportunity to ameliorate this in the short-term by using some of the additional federal SNAP administrative funding that is available but this is not a long-term solution. In the coming months and years, these challenges will require our best thinking in order to continue directing more federal dollars to our state and, thereby, increasing the resources available to low-income families.

Human Service Category: Food and Nutrition

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
Food Support for Low-Income Families				
DHS	Supplemental Nutrition Assistance Program (SNAP)	The Supplemental Nutrition Assistance Program (SNAP) helps low-income people and families buy the food they need for good health. Benefits are provided on the Link Card. The program is managed by the Food and Nutrition Service (FNS) of the United States Department of Agriculture. The Department of Human Services administers the program in Illinois.	Improve Nutrition	$2,118,901,101
DHS-CHP	WIC Women, Infants Children	To improve the health and nutritional status of women, infants and children; to reduce the incidence of infant mortality, premature births and low birth weight; to aid in the development of children; and, to make referrals to other health care and social service providers	Improve Nutrition	$299,670,000
DHS	Supplemental Nutrition Assistance Program (Administrative)	The Supplemental Nutrition Assistance Program (SNAP) helps low-income people and families buy the food they need for good health. Benefits are provided on the Link Card. The program is managed by the Food and Nutrition Service (FNS) of the United States Department of Agriculture. The Department of Human Services administers the program in Illinois.	Meet cost of administering the program	$209,015,693
DHS-HCD	Emergency Food Program (TEFAP)	Provides emergency food through pantries, soup kitchens and homeless shelters.	Meet the emergency food needs of clients.	$3,727,985
DHS-HCD	SNAP Outreach	Provide outreach to potentially eligible SNAP recipients.	Encourage participation in the SNAP program.	$1,086,202
DHS-HCD	The Emergency Food Assistance Program ARRA	Provides emergency food through pantries, soup kitchens and homeless shelters.	Meet the emergency food needs of clients.	$1,060,048

DHS-CHP	Commodity Supplemental Food Program	The purpose of the program is to reduce early deaths, increase productivity, improve quality of life for seniors, and combat infant mortality through nutrition and nutrition education	Improve Nutrition	$910,000
DHS-CHP	Farmer's Market Nutrition Program	To promote the routine consumption of fruits and vegetables as a part of the daily diet.	Improve Nutrition	$0

Food Support for Seniors

DOA	Title III Nutrition	Provides federal funding for home delivered meals and congregate meals.	Clients receive nutritional meals.	$24,475,800
DOA	Nutrition Services Incentive program	Provides federal funding for home delivered meals and congregate meals.	Clients receive nutritional meals.	$8,500,000
DOA	HDM and Mobile Food Equipment	Supports the federal Older Americans Act nutrition program. Prevents unnecessary institutionalization of frail seniors 60+ by delivering meals to their homes.	Clients receive nutritional meals that they are not able to prepare for themselves.	$7,969,600
DOA	ARRA Nutrition Services	Provides additional federal funding for home delivered meals and congregate meals.	Clients receive nutritional meals.	$5,000,000
DOA	Home Delivered Meals	Prevents unnecessary institutionalization of frail seniors 60+ by delivering meals to their homes.	Frail clients receive nutritional meals they aren't able to prepare themselves.	$2,000,000
DOA	National Lunch Program	Provides federal funding to reimburse community-based non-residential adult day service centers for meals served dependent upon the type of meals served, client income, and meal counts.	Improves the diets of persons age 60 and over and functionally impaired adults by providing adult day centers with reimbursement for nutritious, well-balanced meals. Provides adult day centers with supplemental funding for food costs.	$1,500,000
DOA	Child/Adult Food Care	Provides federal funding to reimburse community-based non-residential adult day service centers for meals served dependent upon the type of meals served, client income, and meal counts.	Improves the diets of persons age 60 and over and functionally impaired adults by providing adult day centers with reimbursement for nutritious, well-balanced meals. Provides adult day centers with supplemental funding for food costs.	$200,000

Food Support for Children in Low-Income Families

ISBE	Child Nutrition Programs	To reimburse participating sponsors for a portion of cost of providing nutritious meals (breakfast, lunch, supper, & snack) & milk to eligible children. This includes the Illinois Free Lunch and Breakfast program, through which all public schools are mandated provide a nutritious lunch to all qualifying students; the Child and Adult Care Food Program (CACFP); & Summer Food Service Program (SFSP).	Provide leadership and support for sponsoring entities to provide nutritious meals to children enabling children to properly learn and grow.	$675,000,000
ISBE	Illinois Free Lunch/Breakfast	Required State matching funds to ensure further federal funding for the Illinois Free Lunch and Breakfast Program.	To provide leadership and support for sponsoring entities to provide nutritious meals to children enabling children to properly learn and grow.	$26,300,000
ISBE	Child Nutrition Programs - ARRA	To reimburse districts for the costs associated with purchasing new equipment for school cafeterias.	To improve school cafeterias so sponsoring entities can provide nutritious meals to children enabling children to properly learn and grow.	$3,657,300
ISBE	School Breakfast Incentive Program	To ensure that students receive enough food and nutrients so they are capable of learning and performing at a high level. The School Breakfast Incentive Program is designed to encourage school districts to increase the number of school buildings that offer school breakfast programs and to increase the number of students that participate in school breakfast programs.	To provide leadership and support for sponsoring entities to provide nutritious meals to children enabling children to properly learn and grow.	$361,800

HEALTH CARE AND SUPPORT

Overview

One of the largest areas of the human services system in Illinois addresses the health care and support needs of people who are Medicaid-eligible. Illinois also offers programs that target the special needs of seniors, people with HIV / AIDS and reproductive health, for both Medicaid and non-Medicaid populations. Given the size and specificity of these programs, they are organized and discussed by the following areas:

- Medicaid and related medical assistance programs
- Health screening and support
- Reproductive and early childhood health, and
- Health services for older persons

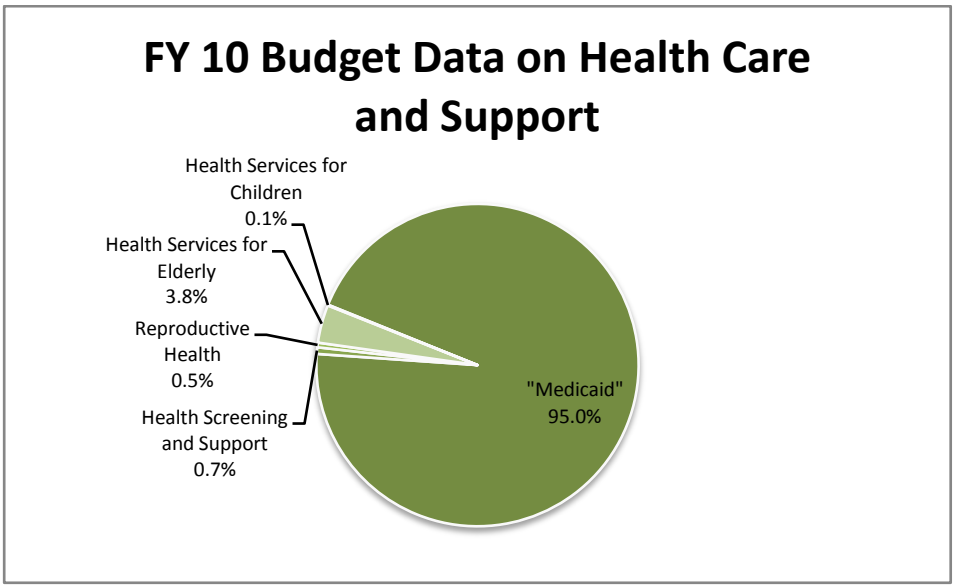
(A smaller set of health services for children is summarized in this section's charts and end table, but is not discussed in this report.) Each area covers the general purpose, populations served, the service delivery system, funding, and critical issues and trends.

The state agencies that are involved with this area of the human services system are the Department of Aging (DOA), Department of Healthcare and Family Services (DHFS), Department of Human Services (DHS) and Department of Public Health (DPH). According to data provided by these agencies, health care and support programs were funded at the following levels in FY 10:

FY 10 Budget Data on Health Care and Support

	Total
	$15,658,435,060
Medicaid and Related Medical Assistance Programs	$14,875,155,200
Health Screening and Support	$102,570,700
Reproductive and Early Childhood Health	$72,918,660
Health Services for Elderly	$596,244,000
Health Services for Children	$11,546,500

These figures are visually illustrated in the following chart:



MEDICAID AND RELATED MEDICAL ASSISTANCE PROGRAMS

Overview: The Department of Healthcare and Family Services (DHFS) has principal responsibility for the state's medical assistance programs, which provide access to health care services, primarily for low-income families with children and for elderly and disabled individuals. About 95 percent of total medical assistance spending is funded through Medicaid, with the federal government typically covering one-half of the costs.[1] Most of the remainder is jointly financed through the Children's Health Insurance Program (CHIP), which involves a higher federal matching rate of 65 percent. A small portion of medical assistance spending (including the All Kids expansion) is funded entirely by the state.

A substantial amount of DHFS medical assistance spending is financed outside the General Revenue Fund (GRF). For many of these special state funds, the non-federal share of Medicaid costs is covered not by state revenue but by provider assessments (the Hospital Provider Fund and Long Term Care Provider Fund) or local government funds (the County Provider Fund and Juvenile Rehabilitation Medicaid Matching Fund).

DHFS accounts for about 80 percent of total Medicaid spending in Illinois. Other agencies with responsibility for Medicaid-funded services include the Department of Human Services (DHS), the Department on Aging (DOA), the Department of Children and Family Services (DCFS), the Department of Public Health (DPH), and the State Board of Education (ISBE). However, DHFS, as the designated single state Medicaid agency, is responsible for oversight and claiming of all Medicaid spending.

Populations served: There are four major groups eligible for comprehensive medical assistance benefits: children under age 19, seniors, adults with disabilities (ages 19-64), and other non-elderly adults, including parents and other caretaker relatives raising depending children and pregnant women. In

[1] The enhanced federal matching funds (approximately 62 percent for Illinois) available to states on certain services under the American Recovery and Reinvestment Act (ARRA) of 2009 were extended through June 30, 2011 under the recently enacted Patient Protection and Affordable Care Act (PPACA).

addition, DHFS administers some partial benefit programs such as Illinois Healthy Women (family planning services) and Illinois Cares Rx (Medicare Part D wrap-around).

Under federal law, Medicaid covers children under age six up to 133 percent of federal poverty level (FPL) and older children up to 100 percent of FPL.[2] In Illinois, CHIP covers children above the Medicaid income limits up to 200 percent of FPL. (The state raised its CHIP eligibility limit from 185 percent to 200 percent of FPL in July 2003). The All Kids expansion, implemented in July 2006, offers coverage for children who are not eligible for Medicaid or CHIP, regardless of family income, health status or immigration status.

In most instances, eligibility for All Kids expansion requires children to have been uninsured for 12 months prior to enrollment. Some children, however, are exempt from the waiting period: those with a parent who has lost employment that offered affordable dependent health insurance coverage, newborns whose responsible relative does not have access to affordable private or employer-sponsored health insurance, and children who have lost Medicaid or CHIP coverage within the previous year.

Parents and relative caretakers are covered under "FamilyCare," which was funded primarily through CHIP from October 2002 to September 2007 and is now funded through Medicaid. The income eligibility limit for FamilyCare was initially set at 49 percent of FPL and was gradually raised to 185 percent of FPL in January 2006.

The "Moms and Babies" program provides a full range of health benefits to eligible pregnant women and infants up to one year of age. Under federal law, Medicaid covers pregnant women with incomes up to 133 percent of FPL. In Illinois, the income eligibility limit is 200 percent of FPL.

Through June 2000, the effective income eligibility limit for elderly and disabled Medicaid recipients in Illinois was only 41 percent of FPL. The state gradually raised the eligibility ceiling to 100 percent of FPL in July 2002. Nearly all elderly recipients and a substantial portion of disabled recipients are "dual eligibles" who are enrolled in both Medicare and Medicaid.

Children account for almost 60 percent of medical assistance enrollment but only 28 percent of spending. The elderly and disabled represent 17 percent of enrollment and more than 50 percent of spending, as illustrated in the next table.

The major eligibility groups also have very different patterns of service utilization. Children and parents account for 70 percent of spending for physician services and 50 percent of spending for hospital services. Disabled recipients represent more than 30 percent of spending for long-term care, hospital services and prescription drugs. The elderly account for 65 percent of long-term care spending.

Total Medicaid enrollment, as of October 2009, was 2.5 million, with the following distribution by eligibility group:

[2] See Appendix H for a table with FPL levels and figures.

Medical Assistance: DHFS (GRF and related funds only)			
	FY 09 Enrollment	FY 09 Spending	FY 08 Cost Per Enrollee
Children	59 percent	28 percent	$1,527
Non-disabled adults	25 percent	20 percent	$2,820
Adults with disabilities	10 percent	31 percent	$10,624
Seniors	7 percent	20 percent	$9,825

Enrollment in the state's medical assistance programs rose from about 1.5 million in June 2001 to 2.5 million in June 2009. Enrollment increased at an average annual rate of 7.3 percent from FY 01 to FY 05 and a rate of 5.6 percent from FY 05 to FY 09. Much of the enrollment growth resulted from expanded eligibility for children under CHIP and All Kids, as well as for low-income parents under FamilyCare. In addition, the state raised its Medicaid income eligibility limit for the elderly and disabled from 41 to 100 percent of FPL. During this same period, Illinois established the state-funded "SeniorCare" prescription drug program (now "Illinois Cares Rx").

Average Annual Enrollment Growth		
	FY 01-FY 05	FY 05-FY 09
Children	5.3 percent	7.2 percent
Non-disabled adults	15.9 percent	4.7 percent
Disabled adults	5.2 percent	1.0 percent
Seniors (excluding Senior Care)	4.6 percent	2.0 percent
Total	7.3 percent	5.6 percent

All Kids has had direct and indirect effects on children's enrollment. The All Kids expansion offers coverage for uninsured children who are not eligible for Medicaid or CHIP. In addition, All Kids outreach and a unified application process have had positive spillover effects on Medicaid and CHIP. In June 2009, more than 1.6 million children were enrolled in DHFS medical assistance programs, including 85 percent in Medicaid, 11 percent in CHIP, and four percent in All Kids expansion.

Service Delivery System: For most enrollees, DHFS medical assistance programs offer a comprehensive array of services, including mandatory Medicaid services and most optional Medicaid services. Service providers include hospitals, nursing facilities, physicians, community health centers, pharmacies, laboratories and home care providers. Hospital services, long-term care and outpatient prescription drugs account for more than 70 percent of medical assistance spending from GRF and related funds. DHFS has a managed care program consisting of two delivery systems: the statewide Primary Care Case Management (PCCM) program and, in certain counties of the state, Managed Care Organizations (MCOs). These programs, which reflect the national healthcare reform goals of coordinating care and

evaluating health outcomes, efficiencies and performance, covered approximately 1.9 million of DHFS's participants as of April 2010 (1.7 million under PCCM and 200,000 under MCOs).

Medical Assistance Expenditures by Type of Service: GRF and Related Funds, FY 09 (in $ millions)		
Hospital services	$3,514.0	34.2 percent
Long-term care	2,052.9	20.0 percent
Prescribed drugs	1,884.9	18.3 percent
Physicians	943.2	9.2 percent
Medicare premiums	303.4	2.9 percent
Community health centers	297.7	2.9 percent
Managed care organizations	265.5	2.6 percent
Dentists	205.5	2.0 percent
Transportation	110.5	1.1 percent
Appliances	106.7	1.0 percent
Hospice care	96.9	0.9 percent
Home health care	85.6	0.8 percent
Specialized care for children	72.8	0.7 percent
Laboratories	67.4	0.7 percent
Children's Mental Health Initiative	29.5	0.3 percent
All other benefits/services	249.6	2.4 percent

Services for children: The child health component of Medicaid is the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. In Illinois, service coverage for children under Medicaid and CHIP is identical. Under All Kids expansion, service coverage is almost the same.

In November 2005, a federal district court gave final approval to a consent decree in *Memisovski v. Maram*, a class action lawsuit on behalf of Medicaid children in Cook County. A year earlier, the court had held that Illinois had been violating federal law by failing to ensure that all eligible children have adequate access to pediatric care and by failing to provide timely primary, preventive and diagnostic services (under Medicaid EPSDT). The remedies in the consent decree include substantial increases in Medicaid reimbursement rates for targeted primary care services.

Long-term care: Long-term care facilities include nursing homes, supportive living facilities, and "Institutions for Mental Diseases" (IMDs), which are essentially nursing homes with more than 16 beds that provide care for individuals with mental illnesses. Under federal law, Medicaid covers IMD services

only for individuals who are under age 21 or age 65 and older. Consequently, much of the cost of IMD services in Illinois is covered entirely with state funds.

In response to reports of violence, neglect and substandard care in many nursing homes, the Governor appointed a Nursing Home Safety Task Force, which issued a report in February 2010.[3] The report concluded that nearly all of the state's nursing homes, as well as applicable state regulations, are designed for older adults. Younger residents with serious mental illness who can benefit from living in a community should be served in specially designed and monitored community residential settings. The report recommended better prescreening for all populations. The report also included recommendations to improve the quality of services for vulnerable older adults who need nursing home care, in addition to discussing the need to rebalance long term care funding towards community services. Legislation to address safety concerns in general, through higher mandatory minimum staffing levels, and the younger mentally ill population in nursing facilities in particular, through required training and certification, passed the General Assembly in May 2010.

The state's reliance on IMDs was challenged in a class action lawsuit originally filed in August 2005. In a tentative agreement reached in March 2010 (*Williams v. Quinn*), about 4,500 people with mental illness will have the opportunity to move out of nursing homes and into community-based settings. The transition will occur over the next five years.

Under Medicaid, Illinois offers nine home and community-based services (HCBS) waiver programs for individuals with special needs who would otherwise require institutional care. All but one waiver includes day-to-day operation by another state agency. DHFS administers the waiver program for supportive living facilities. For the other eight, DHFS provides oversight, program monitoring, fiscal monitoring and administrative coordination to secure federal funding. Other HCBS waivers are administered by the Department of Human Services, the Department on Aging and the University of Illinois Chicago, Division of Specialized Care for Children (DSCC).

Managed care: In FY 07, DHFS began implementation of a new Primary Care Case Management (PCCM) program affecting most recipients of medical assistance in the state. Under the PCCM program clients are enrolled with a medical home or primary care physician to assure access and coordination of all medical services. The state's PCCM program, "Illinois Health Connect" (IHC), is intended to improve the quality of care and increase utilization of primary and preventive care while reducing the usage of the emergency room care for routine medical care.

DHFS has also instituted a voluntary, statewide Disease Management (DM) program, "Your Healthcare Plus" (YHP). In recent years, many states have adopted DM as a tool for controlling costs and improving coordination and quality of care for individuals with chronic illnesses, who account for a disproportionate share of Medicaid spending.

Continuing its efforts to enhance care management and health outcomes through medical homes, DHFS has begun to implement an integrated managed care pilot program for approximately 40,000 older adults and adults with disabilities in suburban Cook, DuPage, Kane, Kankakee, Lake and Will counties. The pilot, which will be phased in over several years, beginning with all non-long-term care services, is

[3] Available at http://www2.illinois.gov/nursinghomesafety/Documents/NHSTF percent20Final percent20Report.pdf

targeted to start in the last quarter of 2010. Since the RFP states that people who have dual eligibility (receive Medicare and Medicaid) are excluded, the program will mostly serve disabled adults.

Community health centers: While it is outside of the scope of this report, it should be noted that federally qualified health centers (FQHCs) are an important part of the service delivery system for Medicaid recipients, the uninsured, and other low-income populations in medically under-served areas. In 2008, FQHCs and rural health clinics served almost a million patients at 570 sites across the state.[4] Under the American Recovery and Reinvestment Act (ARRA), the federal government has awarded $93 million in direct grants to community health centers in Illinois. These grants will be used for service expansion, capital improvements and new facilities.

Funding: Medicaid financing is very complex and the impact of Medicaid spending on the state budget is often misunderstood. For most state programs, federal revenue is kept separate from GF, whereas for Medicaid and CHIP, the federal revenue (matching funds) are not. In FY 08, DHFS medical assistance and the State Board of Education (ISBE), the two largest parts of the GF budget, each represented 23 percent of total spending. After excluding federal revenue, however, ISBE accounted for 28 percent of spending, compared with 13 percent for Medicaid. ISBE spending has a much greater impact on the state's own fiscal resources.

Medical assistance programs in Illinois have had chronic problems of delays in payments to service providers, largely because of inadequate appropriations. Under Section 25 of the State Finance Act, payments to health care providers for services within a given fiscal year can be deferred to the subsequent fiscal year. The statute puts no limit on the dollar amount of these liabilities. At end of FY 08, Section 25 liabilities for medical assistance exceeded $2 billion.

Another consequence of Section 25 deferred liabilities is that year-to-year changes in medical assistance expenditures are often different from the year-to-year changes in incurred liabilities. For analysis of the effects of policy changes or enrollment trends, data on medical assistance liabilities, which represent the fiscal year in which expenses are incurred rather than the fiscal year in which payments are made, are more accurate.

Between FY 01 and FY 05, DHFS medical assistance liabilities (for GRF and related funds) increased at an average annual rate of 8.7 percent. This reflected both enrollment growth among all major eligibility groups and rising health care costs, especially for prescription drugs. From FY 05 to FY 09, the annual growth rate was much lower: 4.4 percent. Enrollment growth increased for children but subsided for other eligibility groups. Another factor was the implementation of Medicare Part D in January 2006. Prescription drug coverage for seniors and some disabled individuals was shifted from Medicaid to Medicare. (States are nonetheless required to cover part of the cost through “clawback payments” to the federal government.)

Because of ARRA’s Medicaid provisions, state budgets for FY 09 and FY 10 must be considered together. In order to protect and maintain state Medicaid programs during the recession, ARRA instituted a temporary increase in federal Medicaid matching funds. For Illinois, the federal share of Medicaid costs was raised from 50 percent to more than 60 percent, retroactive to October 2008. In order to qualify for the enhanced federal match, states could not make eligibility standards or enrollment procedures more restrictive, and they had to assure prompt payments to hospitals, nursing homes, and medical

[4] National Association of Community Health Centers, “Illinois Health Center Fact Sheet.”

practitioners (in most cases, within 30 days). This latter requirement compelled Illinois to reduce its backlog of deferred Medicaid liabilities, which stood at $2 billion at the end of FY 08. By the end of FY 10, the GRF will have received about $1.4 billion in federal revenue. Enhanced federal matching funds for Medicaid are scheduled to expire at the end of December 2010 (halfway through FY 11).

The original GRF appropriation for DHFS medical assistance in FY 09 was $6.9 billion, a small increase from the previous year. In response to ARRA, a supplemental appropriation brought FY 09 funding up to $8.4 billion. The GRF medical assistance budget for FY 10 was about $6.6 billion.

Critical Issues and Trends: The critical policy challenges in Medicaid involve access to services, quality of care, and cost containment. Because Medicaid is a federal entitlement program, spending in a given year cannot be directly controlled by limiting appropriations. In the absence of policy changes affecting eligibility standards or service coverage, program costs are determined by enrollment, service utilization, and payment rates for health care providers.

Health insurance coverage, especially for low-income households, enhances both economic security and access to health care. Research shows that both children and adults without health insurance are less likely to have a usual source of care, less likely to receive preventive care, and more likely to have unmet health care needs. The expansion of medical assistance eligibility for children in Illinois has resulted in significant improvement in health insurance coverage. In 2007-2008, 6.5 percent of Illinois children lacked health insurance, compared with 10.4 percent in 2004-2005. Improvements in health insurance coverage have been particularly striking for Latino and African-American children. The uninsured rate for Latino children dropped from 22 percent in 2002-2003 to 10 percent in 2007-2008. Among African-American children, the uninsured rate declined from a high of 17 percent in 2005-2006 to 10 percent in 2007-2008.

Looking ahead, the future effects of health care reform are a critical issue. The federal Patient Protection and Affordable Care Act (PPACA) requires states to maintain current Medicaid eligibility standards for adults until January 1, 2014, and Medicaid and CHIP eligibility standards for children until October 1, 2019. Beginning in 2014, Medicaid will be expanded to cover all individuals under age 65 with incomes up to 133 percent of FPL. As under current law, undocumented immigrants will not be eligible for Medicaid.[5] The federal government will cover the full cost of the expansion for 2014-2016. The federal share will gradually phase down to 90 percent in 2020 and subsequent years. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP matching rate. For Illinois, this will increase the CHIP matching rate from 65 percent to approximately 88 percent. In addition, Medicaid payment rates for primary care physicians will be increased to 100 percent of Medicare payment rates in 2013 and 2014. The federal government will cover the full cost of the rate increase.

HEALTH SCREENING AND SUPPORT

Overview: Health Screening and Support programs address basic population screening and various high-prevalence conditions. By far, the largest amount of funding goes to care for those affected with

[5] Under the 1996 federal welfare reform law, most legal immigrants must undergo a five-year waiting period for Medicaid or CHIP eligibility. The Children's Health Insurance Program Reauthorization Act of 2009 gave states the option of providing Medicaid and CHIP benefits to immigrant children and pregnant women without the five-year delay.

HIV/AIDS for myriad services through ten consortia that cover the entire state. These services span treatment, case management, funding for therapeutics, HIV screening, monitoring, surveillance and state and federal reporting duties. The funding is via a 2:1 federal match; the state has a mandatory 50 percent contribution for each federal dollar.

The second largest program is the Illinois Breast and Cervical Cancer Program (BCCP) created in 2001 with a 3:1 federal match. It was expanded about five years ago after mass advocacy by women's health and cancer advocates and a response to expand by then-Governor Blagojevich. This program provides access to screening and diagnostic services for any woman without adequate health insurance. Women diagnosed with cancer through a BCCP screening, as well as women who are diagnosed outside of the program but meet the eligibility requirements for BCCP, are eligible to receive treatment services covered by DHFS.

The state's participation in immunization distribution, monitoring, etc. is a federal program that does not require a state match, but the state chooses to match it. A significant funding stream exists for community health center expansion as a route to expanding access to healthcare. This is a state-funded effort without federal matching funds. Community health centers do, however, receive Medicaid reimbursement as well as direct federal grants.[6] The remaining programs include additional line items for community health centers and access to health services grants, lead screening and monitoring of high-risk children and school based sodium fluoride programs.

Populations served: The top two high-dollar expenditures, DPH's HIV/AIDS program and DHFS's BCCP, provide services for potentially disabling and mortal conditions to uninsured groups who are diagnosed with or at risk for these conditions. For HIV/AIDS the eligibility is having the conditions and being at 500 percent of the poverty level, which means that most who apply to receive free services are eligible. For the BCCP, women must be living in Illinois, be without insurance and be 35 to 64 years old, or be otherwise symptomatic.

The remaining programs in this area provide population-based screening for genetic or potentially morbid conditions (sickle-cell or other genetic conditions) and requisite monitoring for the population, not determined by their income.

In 2007, approximately 3,000,000+ people were supported by these screening and support programs, including 75,000 screening for HIV and over one million doses of vaccines provided to over 2,800 providers throughout the state. Eight thousand people received free HIV medications for treatment. Forty thousand women participated in BCCP.

Another key trend that affects the populations served is the status of the economy including access to jobs, stable housing, and access to health insurance. People are losing jobs, and with that their means to pay for healthcare services or to keep their health insurance. This signals a need for continued integration of social and medical services to keep the populations stable.

Additionally, the broad income requirement to the HIV/AIDS program (500 percent of FPL) removes a barrier to the program, making it nearly an entitlement. The BCCP program has grown to nearly 40,000 women who qualify because they are uninsured and do not qualify for Medicaid. Again, this makes the

[6] As noted earlier in this section, FQHCs also enhance access to primary care in Illinois, but they are outside of the scope of this report. It should be noted that PPACA includes $11 billion to expand FQHCs.

program function as an entitlement. Therefore, PPACA could be a great stabilizer for programs essentially providing health insurance.

Service Delivery System: Nonprofits and state agencies provide services, coordinating and managing consortia that deliver medical, social, monitoring and screening services, and the provision of medical care. Services are primarily facility based, such as clinics, community centers, public health departments and hospitals. There are three line items coming from the GRF that go to specific health centers in various places in the state designated as having a shortage in primary healthcare services. (These, unlike FQHCs, do not receive federal matches of any kind.) These services are well utilized (i.e., expenditures are increasing), with effective advocates who get increased appropriations.

Funding: Of the total spending in this area, $44 million comes from federal funds; $43 million comes from GRF and $15 million from other state funds. The state has a mandated 2:1 match for the HIV dollars, but contributes much more. The state has a mandated 3:1 match for the BCCP program, but also contributes significantly more.

Critical Issues and Trends: Health screening and support is a necessary human service area now as we do not have access to universal health insurance. Here too, as the federal mandate is implemented, there should be less need for the two top dollar programs. The remaining programs provide mostly population based screening and are relatively stable in their needs.

The HIV epidemic is increasing in certain populations (young African-American people), but decreasing in others (white gay men). Over the last several years, funds for the AIDS drug treatment program has risen because qualification for the program has grown from 200 to 500 percent FPL. This means that the cost of this program will continue to rise. Meanwhile, funds for prevention have steadily dropped, which means that high-risk populations have less benefit of state-funded prevention services.

Looking ahead, implementation of electronic health records and health information exchange holds much promise, as medical, social service, and public health providers have new abilities to streamline care, increase efficiency, decrease costs, increase quality and decrease errors.

Reproductive and Early Childhood Health

Overview: DHS, through its Community Health and Prevention Division, delivers 14 out of 15 programs that have a focus on prenatal health (e.g., nutrition, healthy birth weights, alcohol abstinence); family planning / pregnancy prevention; newborn screening / genetic counseling to reduce death and disability due to metabolic disorders; breastfeeding support and parenting classes. Several programs support very young mothers. Children at-risk of negative birth outcomes are the primary focus of many of these programs.

In FY 10, these programs were funded at a total of $72.9 million, with most of the funds coming from the GRF. It is notable that no public funding exists that addresses the sexual health and wellbeing of youth who are at-risk of unplanned pregnancies from a positive youth leadership development model.

With notable exceptions, little programming exists that presents an approach to reproductive health beyond risk and protective factors.[7]

The limited programming that is geared toward parenting youth focuses on secondary pregnancy prevention, or is directed at their offspring, and primarily exists outside of schools. No programming exists that presents an approach to reproductive health services that cover more than risk and protective factors. Government-funded health care programs such as Medicaid currently do not cover all reproductive health care services equally.[8]

Populations served: DHS reproductive health programs are geared toward women living in at-risk communities (predominantly low-income and communities of color) in the Chicago area. Some target specific communities, particularly Austin and North Lawndale. In terms of population type, twice as many offspring are served than are young mothers/adolescents. One program seeks to increase male involvement. The largest program, Family Case Management, serves more than 300,000 women at risk of negative birth outcomes (very low birth weight) and infant mortality.

Service Delivery System: Most reproductive health services are administered by non-profits, both large and smaller community based groups. When, for example, Illinois received $1.83 million in federal Title V funding in FY 05, it was administered by DHS's Bureau of Child and Adolescent Health and implemented by 29 sub-grantees across the state, reaching nearly 300 public schools.

The Bureau of Child and Adolescent Health also contracted with Project Reality to provide abstinence education in an additional 311 schools. In that same year, there were nine CBAE (Community Based Abstinence Education) grantees in Illinois: Abstinence and Marriage Education Partnership; Carefirst Pregnancy Center; Carenet Pregnancy Services of DuPage; Committee on the Status of Women/ Project Reality; the Confederation of Spanish American Workers; the Family Centered Educational Agency; Lawndale Christian Health Center; Rend Lake College; and Roseland Christian Ministries. There was also one Adolescent and Family Life Act grantee, the Lake County Health Department Community Health Center.

Services are narrowly targeted toward pregnancy prevention (first or subsequent) and toward improving the birth outcomes/child's health. Teen pregnancy programs focus on a prevention model. Indeed, a requirement for enrollment in the Illinois Subsequent Pregnancy Project is to prevent an unplanned pregnancy for an 18-month period.

Chicago was once home to three schools for pregnant and parenting youth, but currently only one, Simpson Academy for Young Women, is still in operation. No other alternative school of its kind exists in the entire state. Serving youth from the seventh to eleventh grades, Simpson does not graduate

[7] The main exceptions are Title X Family Planning and School-Based Health Center programs administered by DHS-CHP. The Title X program provides basic reproductive health care services, including family planning education, pap test, STD screening and contraceptives. The School-Based Health Center program is discussed in the Education Support section of this report.

[8] DHFS notes that it has administered the federal demonstration waiver Illinois Healthy Women since April of 2004. Illinois Healthy Women program, which has served an unduplicated total of 83,049 women, extends coverage for reproductive healthcare to women not otherwise eligible for programs. Coverage includes family planning (birth control) and certain services rendered at family planning visits, such as the physical exam, pap tests, lab tests for family planning, testing and medicine for sexually transmitted infections and sterilization found during a family planning visit. Illinois Healthy Women also covers mammograms, multivitamins and folic acid if they are ordered by the doctor during the family planning visit. In fiscal year 2009, DHFS' fee-for-service and IHW programs paid for $126 million in family planning services.

students. However, on average 70 to 80 percent of Simpson students go on to graduate from their home schools or receive their G.E.D. certificate.

Cradle to Classroom remains one of the only programs that has been researched and proven to improve graduation rates among teen parents and to ensure their children matriculate into pre-school. The program had a dual focus to promote educational success among young parents it served and to promote the health and development of their children. An unexpected bonus was that the vast majority of participants did not get pregnant again before graduation. Research found that more than 90 percent of program participants graduated from high school. Cradle to Classroom was active from 1997-2004. At its peak in 2002, this program served 2,500 young parents and 2,235 infants: approximately one-third of infants born to adolescents that year. The program budget was just over $5 million per year at Chicago Public Schools, and nearly 75 percent of the costs were reimbursed by the state.

Funding: More than 78 percent of the budget allocations are for improving the birth and health outcomes of children born to women living in at-risk communities. The remaining 22 percent of funds are for preventing pregnancies in the first place. There are virtually no state dollars for comprehensive sexuality or sexual health education.

Critical Issues and Trends: Illinois youth often find themselves unequipped to deal with reproductive health, a major aspect of their development. Problems and effective solutions are disconnected in the public health, medical, and educational spheres. This has also left a small minority of people to pass policies, secure funding, and develop resources that often reflect only one subset of values—morals that often rely on dishonesty, bigotry, and shame to promote their values without equipping adolescents and families with information and skills to navigate this lifelong, challenging issue.

Most funding available for educational programs is divided by topic or expected outcome, rather than by the meaning that all of this information might hold in the life of young people. HIV/AIDS and STI prevention, adolescent pregnancy prevention, sexual assault prevention, etc., are each treated separately.

National policy governs this field, and therefore one major issue has been the rise of the abstinence-only-until-marriage (AOUM) industry in the U.S., with Illinois agencies leading the way. This industry was built with federal dollars beginning in the early 1980s with the Adolescent Family Life Act's chastity programs, gained credibility with a $50 million per year allocation through Title V funding in the mid-90s, and culminated in a direct-to-organizations grants program established in 2000 called the Special Projects of Regional and National Significance: Community-Based Abstinence Education (SPRANS-CBAE). The Bush Administration increased funding for the CBAE program each year, finally reaching $113 million in FY 08. Of that, $10 million was allocated to Illinois.

AOUM programs have the following traits:

- Limited to teaching about abstinence-only-until-marriage
- Do not address the experiences of lesbian, gay, bisexual, transgender and queer students who cannot marry
- Do not address the experiences of students who have been sexually abused
- Cannot discuss the health benefits of contraceptives

- Focus heavily on and exaggerate the ineffectiveness of STD/STI and pregnancy prevention tools.

In recent years, the general public has become more aware of and concerned about the use of public dollars to support AOUM programs and their questionable practices. Nearly half of all states opted out of receiving federal dollars through the former Title V program. In FY 09, Congress made the first cut to AOUM funding, decreasing the SPRAN-CBAE grants by $13 million. That year, one of the AOUM industry leaders in Illinois, Project Reality, closed its doors and merged with the Abstinence and Marriage Education Partnership. In December 2009, Congress signed into law an omnibus-spending bill that eliminates all spending for AOUM programs and redirects the funding to a Teen Pregnancy Prevention Initiative for evidence-based and innovative programs.

The new initiative, with $114.5 million in funding for FY 10 and $133.7 million proposed by President Obama for FY 11, will be administered by the newly created Office of Adolescent Health within the U.S. Department of Health and Human Services with a mandate to support "medically accurate and age appropriate programs." The initiative's focus on pregnancy prevention leaves out other sexual health topics such as STIs, including HIV, and the needs of gay, lesbian, bisexual, transgender and queer youth.

Congress recently passed and signed into law health care reform (PPACA). It includes $375 million ($75 million per year for 5 years) in funds for programs that prevent adolescent pregnancy and sexually transmitted infections (Personal Responsibility and Education programs). The Centers for Disease Control and Prevention would administer the money, requiring states to match every four federal dollars with one state dollar. An additional $250 million ($50 million per year for five years) was included to reinstate Title V funds for AOUM.

Health care reform legislation also includes authorization and appropriations for a Pregnancy Assistance Fund, with some funds to be distributed to states that may be used for grants to institutions of higher education to support pregnant and parenting college students, grants to high schools or community-based organizations to support pregnant and parenting secondary school students or for other purposes.

Pregnant and parenting youth face significant challenges as they work to succeed in life. Too often, they struggle to balance the demands of completing high school, caring for children, navigating their own adolescence and trying to forge a future in which they can provide a safe and healthy home. Support from family, friends, schools, and the greater community is essential to the long-term success of pregnant and parenting youth, particularly in the education setting.[9]

HEALTH SERVICES FOR SENIORS

Overview: Illinois has developed the largest home care program in the nation in the Illinois Community Care Program (CCP). Since 1984, the Illinois Department on Aging (DOA) has administered a statewide entitlement program for older persons with high physical and / or psychological impairments, few assets and low income. Its goal is to provide alternatives to facility based care, which is often more expensive, less safe due to communal diseases and less desirable to seniors.

[9] See the Early Childhood Education discussion in the Individual and Family Support section of this report for information on programs that focus these needs.

CCP has, until recently, provided homemaker services and, in many locations, Adult Day Services. In 2006, Emergency Home Response System devices were added to the service menu for qualified participants. CCP does not, however, provide personal attendant services.

Illinois also provides Comprehensive Care Coordination for all individuals and families considering long term care and universal prescreening for older and disabled persons leaving hospital settings to assure appropriate planning. For individuals who require facility based care, DOA along with 13 Area Agency on Aging partners, has established the Older Americans Act (OAA) Long Term Care Ombudsman service, a unique program dedicated to independently protect older nursing home residents through responses to complaints and regular presence in the homes. Forty percent of nursing home residents have no family or friends visiting them, which means that the Ombudsman program is their only resource for assuring safety and well being.

Finally, a smaller OAA program, Title III Preventative Health (referred to as Health Promotion/Disease Prevention in this discussion) establishes additional health services through organizations that disseminate information on prevalent health care conditions and issues and recently provided the beginning of evidence based health promotion in Illinois.

Populations served: The numbers of older people in need of chronic care assistance have increased with longer life expectancies. Demographic birth dips from the Korean War period reduced the size of the long term care population from 2005 to 2010, but forecasts for growth in the population are staggering as Baby Boomers age.

People served by CCP are for the most part women over the age of 75 who have multiple limitations in their daily living activities. The 60,000 people served by CCP makes Illinois the largest program in the nation. CCP clients have an average Mini-Mental Status Examination (MMSE) score of 22.3, indicating mild cognitive impairment.

Adult Day Services is a service of CCP but client numbers are smaller due to a limited number of providers in parts of the state. The Ombudsman program serves people in nursing homes and assisted-living facilities where over 100,000 people reside. The program performed 7,673 investigations in 2009. Health Promotion/Disease Prevention serves the general population that is vulnerable to repeated hospital placements and high utilization of medical services. The FY 10 target for this program is to serve 31,777 individuals. In addition, 1,738 individuals are targeted to receive a health screening.

A notable trend is the preference for self-directed care, which means that more family relatives will be caring for older and disabled relatives, hours of service provision will be determined by consumers and the risk and responsibility for the care plan will shift from care coordinators and contracted agencies to the individuals receiving service. National studies indicate that the outcomes of this shift are positive, although some in Illinois are seeking to avert this risk (with increased costs). Identifying future home care staff is also a concern to provider agencies, as the turnover of aides is often over 100 percent during a twelve month period.

Service Delivery System: CCP is administered by DOA under Illinois statute and a Medicaid Waiver. DOA contracts essential elements of the program to vendors including approximately 60 Care Coordination Units (not-for-profit groups and local governments), approximately 164 home care contracts and approximately 88 Adult Day Service contracts.

Older persons who request services or who are referred to DOA or Area Agencies on Aging (AAA) are visited by Care Coordination Unit staff and receive an assessment of their ability to perform activities of daily living, incidental activities of daily living and mental health. The assessment score determines the service maximum budget for care for each individual. Homemaker, Adult Day Services, Emergency Home Security Systems, flexible senior services and demonstration services are then assigned based on need. Vendors are assigned to the individual with a detailed care plan.

Care Coordination Units are relied on for other services as well, e.g. home delivered meals and Title III chore or respite services. They also provide Universal Nursing Home Pre-Screening in hospitals to ensure that patients have information needed to make choices on their next care setting upon discharge.

Under DOA's direction, regional Ombudsmen are selected through a competitive process administered by local AAAs or, in some areas of the state, Ombudsmen services are directly performed by Area Agency on Aging staff. They perform regular visits to the state's 1,100 nursing homes and over 300 assisted living facilities. The Ombudsman program was a prominent, knowledgeable player in the discussions related to recent news coverage of mental health and geriatric patient issues in several Chicago nursing homes, yet it is underfunded to the point that it has stopped resident and family education activities and struggles to keep up with reports of nursing home complaints.

Health Promotion / Disease Prevention provides services, screenings and healthy lifestyle education based on the specific needs of the state's 13 planning and service areas. DPH is funding the pilot of an evidence-based health-promotion program called Take Charge of Your Health. This is a regimented course to assist those with chronic diseases to self manage their conditions.

Funding: The FY 10 budget for CCP underfunded the program by at least $60 million. The last quarter of FY 09 was not funded in the FY 09 budget, meaning that the first payments for FY 10 paid expenses incurred in FY 09. Providers report 180-day payment delays. The current FY 10 budget is in deficit once again and further reductions are expected in FY 11.

The Ombudsman and Health Promotion / Disease Prevention programs are funded by OAA resources. The Ombudsman program received a scaled back state GRF allotment, a reduced share of Civil Monetary Funding and new Money Follows the Person (MFP) Medicaid demonstration funding for identifying older persons who may be safely moved from institutional to home and community based settings. Under the MFP demonstration, Illinois received a demonstration award providing time-limited enhanced Medicaid matching funds to use in rebalancing Illinois' long term care system by providing services to eligible nursing home residents who have transitioned to approved community settings. As the lead agency charged with implementing MFP, DHFS works closely with staff from DHS, as well as DOA and the Illinois Housing Development Authority.

DOA has seen the fastest growth of any state Department over the past six years, due to the expansion of the CCP and the addition of the Circuit Breaker Illinois Cares Rx program (which is covered in the Public Assistance section of this report). Increases in CCP are attributable to steady improvements in the pay to home-care workers (including allotments of hourly unit rates towards health insurance costs), increases in asset limits for participants and the addition of Comprehensive Care Coordination, a statewide effort to assure standardized reviews of older persons situations and to better understand the impact of a service plan on their circumstances. Comprehensive Care Coordination is slated for increased funding in the future.

Critical Issues and Trends: This field was shaped in part by *Benson v. Blaser*. Settled in 1982, it mandates that any applicant for CCP services is assessed and served in a timely fashion. Demographic imperatives, a preference for home- and community-based settings, changes in health care approaches such as health promotion and disease prevention, and the cost of alternatives to home and community care services support the importance of CCP.

Today, Illinois is facing legal issues and decision points around the home- and community-based service system. Home care is preferred by many impaired older persons, even if the current budget structure does not always support allocating resources in this direction.

The need to involve families in developing and delivery care plans is clear, but progress in developing the Aging and Disability Resource Centers that are proven to reduce unnecessary institutionalization has been slow and there is concern that Health Promotion / Disease Prevention will not be a priority in this fiscal environment.

Yet CCP is positioned to help sustain large numbers of individuals in their own homes and communities. This will require attention to information systems, decentralized oversight through established networks of services, such as AAAs, communications within the network of service providers and personal attendant care.

Recently passed federal health care reform (PPACA) included a program to incentivize re-balancing Medicaid long-term care by offering an enhanced federal match on state Medicaid dollars spent on HCBS. Illinois will need to prepare to meet the requirements for this program in order to access the enhanced federal funding in 2011.

Also going forward, other notable policy challenges will be: 1) the concept of global budgeting to assure that resources are committed to the program area best able to serve each person's needs; 2) a balanced approach to prevention programs for mildly impaired seniors and care for the chronically ill; 3) a strong Ombudsman presence in all long-term care facilities; 4) coordination of health and service supports for people as they enter and leave health and home/community settings, and 5) a budget system that prioritizes responses based on the numbers reached and effectiveness in achieving positive outcomes.

Human Service Category: Health Care and Support

Data Source: State agencies as indicated in the first column

Medicaid and Other Related Medical Assistance Programs

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DHFS	Illinois Medical Assistance Program	Administers the state's mean tested medical programs and, in conjunction with the federal government, funds medical services for Illinois' most vulnerable low-income residents.	In fiscal year 2009, on average, approximately 2.7 million individuals were enrolled in DHFS' various programs each month. All Kids served about 1.5 million children, an increase of nearly 235,000 over the last 3 years. DHFS focused efforts to improve health outcomes and to assure access and coordination of services through its primary care case management program, Illinois Health Connect serving over 1.8 million clients through a medical home model and its disease management program, Your Healthcare Plus, with over 240,000 eligible participants. DHFS continued its commitment to health outcomes of maternal and child beneficiaries through initiatives designed to improve the health status of women, mothers and children. EPSDT participation rate for the Title XIX (Medicaid) population and for all enrolled children under 21 years of age increased from federal fiscal years 2005 through 2007, resulting in more required EPSDT well child visits being rendered.	$14,875,155,200

Health Screening and Support

IDPH	AIDS/HIV	Provides funding, consultation, training and planning for the provision of medical and social support services to persons living with HIV through ten regional care consortia and community based organizations; purchases HIV-related therapeutic drugs for low income persons living with HIV; oversees and supports the continuation of health insurance coverage for eligible individuals; provides planning, financial support, training and consultation to local health departments in HIV counseling, testing, referral and partner notification services; provides HIV health education and risk reduction information and intervention services to the general public, populations at risk and professionals, both directly and through nine regional programs; and maintains official records for, analyzes, and monitors the extent of the epidemic, reporting results to both government entities and the general public.	1) Maintained nine regional HIV prevention programs and developed regional outreach programs with effective interventions for high risk HIV/AIDS populations. 2) Maintained 10 local HIV care consortia to provide a coordinated continuum of services for persons with HIV. 3) Provided HUD-funded housing programs for homeless or near-homeless persons with HIV in the 10 consortia areas and stabilized housing by providing funds to 17 housing providers statewide. 4) Provided AIDS-designated housing facilities with HUD funds used for operating costs of the facilities, supportive services for persons living with HIV, and rehabilitation and repair of the facilities. 5) Added Title II funded outreach and treatment adherence as available services to persons with HIV. 6) Through collaborations between Direct Services and Counseling and Testing, developed a Linkage to Care Policy/Procedure to increase the number of newly diagnosed HIV individuals who were successfully linked into Ryan White case management and medical care. 7) Maintained the statewide AIDS hotline, Perinatal Hotline and AIDS information service. 8) Provided HIV counseling, testing and referral	$47,900,000

			services to approximately 75,000 persons. 9) Provided assistance in obtaining HIV related pharmaceutical treatments to 7,425 individuals enrolled in ADAP annually. 10) Continued health insurance coverage for approximately 250 individuals with HIV monthly. 11) Implemented opt-in HIV counseling and testing for pregnant women and their newborn infants in hospital-based labor and delivery units statewide. 12) Piloted rapid HIV testing in selected sites around the state. 13) Revised AIDS rules to correlate with CDC recommendation for routine testing in clinical setting. 14) Administered the African American AIDS Response Fund grantees. 15) Provided services to formerly incarcerated HIV positive individuals to assist in their transition to communities statewide. (FY 07)	
IDPH	Breast and Cervical Cancer Program	The statewide program offers free breast and cervical cancer screens and related diagnostic services for women age 35-64 who have no health insurance. Women diagnosed with breast or cervical cancer while enrolled in the program can receive treatment benefits through the Illinois Department of Healthcare and Family Services as a result of the Breast and Cervical Cancer Treatment Act (July 2001). Program efforts include public and professional education, quality assurance, surveillance activities and comprehensive case management that ensures appropriate follow-up for women with abnormal screening results.	During FY 09, the Illinois Breast and Cervical Cancer Program (IBCCP) expanded by adding one new Lead Agency, Northwestern Memorial Hospital. This expansion, with the 10 IBCCP Lead Agencies added during FY 08, will allow IBCCP to serve an estimated 36,000 women in FY 09, an increase of 9,500 over FY 08. (FY 09)	$18,000,000

IDPH	Immunizations	Promotes the use of vaccines to prevent occurrence and transmission of diseases through a federally funded program as mandated by Section 317 of the Public Health Service Act and through the federal entitlement Vaccines For Children program as established through OBRA93; distributes vaccines to over 2,800 public and private providers statewide; conducts surveillance and investigation of preventable childhood and adult diseases; interprets and educates providers, day care centers, schools and colleges on requirements included in Section 665, Section 695 and Section 694 of the Illinois Administrative rules; maintenance of the current TOTS immunization registry and statewide implementation of the web-based registry applications I-CARE; provides education/training to public and private vaccine providers, day care centers, schools, colleges, hospitals and the general public through community partnerships with public campaigns, community coalitions, volunteer groups, vaccine manufacturers, professional organizations and federal agencies; conducts mandatory assessment of vaccine coverage levels among various target populations and conducts quality assurance reviews of clinics and providers using any federally purchased vaccines.	FY 06 to date: Doses of vaccine distributed (excluding Chicago) 1,730.000. Chicago is a separate federal project area and as such receives funding to support the VFC program within its jurisdiction. Over 2,800 providers are enrolled in the VFC-Plus program. (FY 07)	$9,112,600
IDPH	Community Health Center Expansion Grants	Under the auspices of the Community Health Center Expansion Act, provides grants to community health centers to expand services, and to develop new centers to provide primary health care services, and to sustain services to medically underserved and uninsured populations of Illinois.	2 new grantees added for total of 34 grantees. Grants expand services in federally qualified health centers or look-a-likes or add new sites to expand access to care for underserved. (FY 09)	$8,991,000
IDPH	Trauma Center Grants	Awards grants that are used by trauma centers to help fund the provided services.	Through this funding program, approximately $4.963 million was dispersed to Illinois trauma centers. 63 trauma centers received funding. (FY 06	$5,400,000

IDPH	Childhood Lead Poisoning Prevention	Provides screening, medical case management, environmental follow-up and surveillance services for children ages 6 months through 6 years and educational activities related to childhood lead poisoning prevention.	More than 230,000 children are screened for lead poisoning each year. The Department has designated areas of high and low risk across the state; developed physician guidelines for screening, diagnosis and management of lead poisoning; established a statewide surveillance data base; ensured that children with elevated blood lead levels are followed and received appropriate medical treatment and removal of the sources of lead poisoning; provided a clearinghouse of information; and monitored the activities of 81 local health departments covering 94 counties. (FY 02)	$3,734,000
IDPH	Innovations in Long-Term Care Quality Grants	Long-term care grant program that demonstrates the best practices and innovation for long-term care service, delivery, and housing. The grants must fund programs that demonstrate creativity in service provision through the scope of their program or service. Funds will be taken, provided federal approval is obtained, from the federal civil monetary penalties that are collected each year.	Members to the Long-Term Care Quality Grants Advisory Panel is now in place. Currently, there are twelve (12) members on the Committee and one vacancy. (FY 08)	$2,500,000
IDPH	Genetic Counseling/Clinical Services	To reduce death and disability due to genetic diseases by providing assessment, counseling, education and referrals for long-term management related to genetics.	Approximately 14,000 clients receive services annually (FY 07)	$2,000,000
IDPH	Refugee and Immigrant Health Screening	Coordinates the provision of health assessment and screening to Illinois refugees and Orderly Departure Program (ODP) immigrants through the identification, referral for treatment and follow-up of observed health problems includes administrative and interpretation services through identified health agencies	In State Fiscal Year ending June 30, 2008, 5 local health departments and 3 non-for-profit agencies provided bi-lingual health assessment and screenings within 90 days of arrival to 2,500 refugees and ODP immigrants resettling in Illinois. (FY 08)	$1,100,000

IDPH	WISEWOMAN	The Centers for Disease Control and Prevention (CDC) funded program screens and identifies women at risk for cardiovascular disease (CVD). The Illinois WISEWOMAN Program (IWP) participants must first be eligible and enrolled in the Illinois Breast and Cervical Cancer Program (IBCCP). The Program currently serves 11 counties in the State, through 5 Lead Agencies. The WISEWOMAN Program participants may also receive a lifestyle intervention, consisting of 4 weeks of sessions available in English and Spanish.	The Illinois WISEWOMAN Program (IWP) is currently being implemented in 11 counties across the State. The five IWP Lead Agencies are DuPage, Stephenson and Fulton County Health Departments, with St. Mary's Hospital in Marion County and Mercy Hospital in Cook County. During FY 09, all IWP Lead Agencies began implementing a new version of the Program. The curriculum for the lifestyle intervention was reduced from 12 weekly sessions to 4 by eliminating duplication. In addition, IWP added different intensity levels of lifestyle intervention, tailored to participants' risk and readiness to change. The lifestyle intervention curriculum is offered in English and Spanish. (FY 09)	$855,700

IDPH	Dental Sealant	Provides dental sealants to high risk Illinois schoolchildren. Community-based programs provide preventive oral health care, oral health education and referrals to dental homes. The Division provides technical assistance, training, funding, and quality assurance.	First statewide school-based dental sealant program in the country; Since the program's inception, nearly 1,300,000 dental sealants have been provided to nearly more than 575,150 children; all children receive dental examinations fulfilling the 2005 school dental exam mandate; Illinois is over half way toward meeting the Healthy People 2010 objective of 50 percent of children having dental sealants; statewide dental sealant grantee workshops; performance evaluation - quality assurance completed for all grantees; a new data collection system (SEALS) developed by the CDC made available to grantees. The program received the 1996 Illinois Health Promotion Award of Merit. (FY 08)	$608,800
IDPH	Emergency Care Stations	Staffs nurse aide stations at three locations in the capitol complex to provide assistance to visitors and employees.	Continue to provide nursing care at three locations in the Capitol Complex. (FY 06)	$413,400
IDPH	Community Based Organization Grants	Provides grants to community-based organizations and units of local government to promote the development of primary care services in rural areas and designated shortage areas.	1) Monetary awards have been distributed to 6 community based organizations and 1 pending to promote the development of primary care services in rural areas and designated shortage areas. (FY 09)	$392,600
IDPH	Grants to Assist Existing Community Health Centers	Provides grants to community health centers to promote the development of primary care services in rural areas and designated health professional shortage areas.	Awarded 4 grantees (FY 09)	$392,600

IDPH	Emergency Medical Services-Children	Decrease childhood morbidity and mortality by ensuring that appropriate pediatric emergency care resources and capabilities are available across the state.	Conducted renewal site surveys of hospitals recognized through the pediatric facility recognition program as a Pediatric Critical Care Center (PCCC), Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department Approved for Pediatrics (SEDP); Extended the Pediatric Critical Care Center (PCCC) level to additional EMS regions; Evaluated hospital disaster plans during pediatric facility recognition site surveys to assess the inclusion of pediatric components; Assisted with the Pediatric Specialty Team infrastructure development for the Illinois Medical Emergency Response Team (IMERT); Developed and distributed instructional brochures for preparation/dosing of children with antibiotics in an anthrax/plague/tularemia event; Developed and distributed a booklet titled Disaster Preparedness Exercises Addressing the Pediatric Population to assist healthcare organizations in incorporating children into disaster drills and tabletop exercises; Conducted School Nurse Emergency Care (SNEC) courses throughout the state;	$379,300

			Coordinated the activities of the Illinois EMSC Advisory Board and subcommittees; Maintained the web-based EMS Reporting System which provides public access to four statewide databases that provide access to statewide illness/injury/hospitalization trending. (FY 07)	
IDPH	Sickle Cell and Other Hemoglobinopathies	To reduce death and disability due to sickle cell disease and related disorders by screening all newborns for sickle cell diseases and other hemoglobinopathies; by providing information regarding a sickling disease; by providing the required follow-up services to infants who are suspect or diagnosed with a disease/trait; by monitoring the physical and developmental progress of each child who has a confirmed diagnosis until adulthood; and by distributing information about hemoglobinopathies to physicians, healthcare providers and families.	All newborns are screened for sickle cell disease/trait and other hemoglobinopathies. Program staff provide the follow-up services required for the infant who may be suspect and/or diagnosed with disease/trait. The physical and developmental progress of each child with a confirmed sickling diagnosis is followed until adulthood. Hematology centers receive funding to provide the laboratory testing to confirm or rule out the presence of a hemoglobinopathy; ongoing medical treatment and counseling for infants confirmed with a hemoglobin disorder; and counseling for families of infants with trait status. (FY 07)	$288,000

IDPH	Early Childhood Caries Prevention Program	To improve the oral health of Illinois children by collecting data, developing community based programs that provide oral health education and preventive care and referral into dental homes to families of children 0-5 who are at highest risk for this most severe form of dental decay.	The Division of Oral Health interfaces with 142 WIC community partners, 47 Head Start Agencies, and the Illinois Department of Health and Human Services Daycare Nurse Consultants providing early childhood caries (ECC) prevention programming to Illinois families with children under the age of five. Four communities were funded to form coalitions to address ECC. (FY 08)	$160,000
IDPH	Increasing Access to Health Care Services for Medically Underserved Minority Populations through the Expansion of Mobile Health Care	To address the health care crisis the Illinois Department of Public Health Center for Minority Health Services expanded its mobile health care outreach program. Wellness on Wheels currently operates in the Eastern, Central and Southern regions of Illinois and takes life saving services to individuals who otherwise would not have access to any health care services. WOW provides the services in a location and an environment that is non-threatening, targeted, culturally and linguistically appropriate and reality based. Wellness on Wheels provides anonymous HIV prevention counseling, testing, referral, and partner counseling services, urine screening for gonorrhea, and Chlamydia, a blood test for syphilis, blood pressure, blood sugar, and cholesterol screening, a blood test for prostate cancer and referrals to the Illinois Breast and Cervical Cancer Program among other services. These services are provided through collaborative partnerships with local health departments, hospitals, clinics, community based organizations, and other organizations that are certified and licensed to provide clinical services.	During this fiscal year Wellness on Wheels has impacted over 524,000 individuals, provided 1,823 HIV tests, 1,203 blood pressure screenings, 748 blood sugar screenings, 759 blood cholesterol, 463 PSA tests for prostate cancer; and over 750 other miscellaneous examinations. (FY 08)	$159,000
IDPH	School-based Sodium Fluoride Mouth rinse	Conducts programs serving low income schoolchildren in rural areas using a 0.2 percent sodium fluoride mouth rinse solution to prevent dental caries.	In FY 07, 27 oral health sessions (presentations) were given to 2,611 students. (FY 07)	$108,700

IDPH	Arthritis Integration Dissemination Grant	Through this grant program, two evidence-based interventions (EBIs), the Chronic Disease Self-Management Program and the Arthritis Foundation Exercise Program, are being offered to persons with arthritis in two rural areas through a partnership with the East Central Illinois Area Agency on Aging and Southwest Illinois College/Programs and Services for Older Persons. The program is funded by the National Association of Chronic Disease Directors through the U.S. Centers for Disease Control and Prevention.	During the first year of this grant project, the two local partners trained class leaders, recruited class participants, and marketed and conducted new classes through rural partner providers. The Illinois Department of Public Health staff provided program and fiscal support; coordinated monthly update calls; conducted site visits to assess program operation and fidelity to intervention protocol; and developed reports for submission to federal funding source. (FY 09)	$50,000
IDPH	Hospice Service Grants	Provides grants for hospice services. Funding will come from the sale of Hospice license plates. $10 from each initial plate purchase and $23 of the additional renewal charge will go to the Hospice Fund, and the grants will be made from this fund.	none	$25,000

Reproductive Health and Early Childhood Health

DHS-CHP	Family Case Management	The program's goals are to help women have healthy babies and to reduce the rates of infant mortality and very low birth weight.	Improve Birth Outcomes	$42,670,900
DHS-CHP	Family Planning	Family Planning Program services are provided to enable individuals the information and means to exercise personal choice in determining the number and spacing of their children through the provision of effective family planning medical services, methods and education (including abstinence).	Reduce Unintended Pregnancies	$12,154,300

IDPH	Newborn Screening	To reduce death and disability due to metabolic or genetic disorders by monitoring newborn screening for phenylketonuria (PKU), hypothyroidism, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, cystic fibrosis (in 2008), hemoglobinopathies, fatty acid oxidation, organic acid and amino acid disorders by providing medical treatment products to PKU clients and other metabolic disorders; by evaluating long-term progress of diagnosed children; and by providing counseling for individuals or families with, or at-risk of having, genetic disorders.	Approximately 185,000 newborns are screened with the following approximate number of cases identified each year: Phenylketonuria (PKU) - 15; hypothyroidism - 75; galactosemia - 3; biotinidase deficiency - 1; congenital adrenal hyperplasia - 7; and, hemoglobinopathies - 100; fatty acid oxidation disorders - 25; organic acid disorders - 12; other amino acid disorders - 4; cystic fibrosis - 40. (FY 09)	$5,200,000
DHS-CHP	Targeted Intensive Prenatal Case Management	The purpose of the program is to ensure the probability that participants will deliver infants weighing 5.5 pounds or more.	Improve Birth Outcomes	$4,284,700
DHS-CHP	Teen Pregnancy Prevention Primary	To reduce first-time teenage pregnancy, sexually transmitted diseases and HIV/AIDS, improve access to health services and increase the role of the schools in improving pregnancy prevention education and services	Teen Pregnancy Prevention	$2,339,900
DHS-CHP	Health works Illinois	The overall objective of this project is to increase healthy births in North Lawndale and Austin by 20 percent.	Improve Children's' Health	$1,714,800
DHS-CHP	Healthy Start	To reduce the infant mortality rate (the number of babies who die before reaching one year of age) and related health problems for both mother and baby.	Improve Birth Outcomes	$1,440,000
DHS-CHP	Illinois Subsequent Pregnancy Prevention	To help teen mothers delay a subsequent pregnancy by practicing contraception effectively and consistently. It is also designed to help them: graduate from high school, improve their parenting abilities, through curriculum-driven parenting instruction, and ensure that their children are properly immunized, have access to timely well-child check-ups and regular screening for developmental delays.	Teen Pregnancy Prevention	$909,400
DHS-CHP	Healthy Births for Healthy	The overall objective of this project is to increase healthy births in North Lawndale and Austin by 20	Improve Birth Outcomes	$552,700

	Communities	percent.		
DHS-CHP	Breastfeeding Peer Counselor	To improve breastfeeding support, initiation and duration rates, to reduce infant mortality, to improve cognitive abilities and overall long term health benefits of infants and children, and to reduce the incidence of obesity in childhood and later life.	Improve Children's' Health	$445,500
DHS-CHP	Doula	The main objective is to improve the outcomes associated with adolescent childbearing and parenting. The health of adolescent mothers and their children is the primary focus, by reducing the incidence of low-birth weight and poor pregnancy outcomes, and fostering healthy physical, social, emotional and cognitive development of their children.	Improve Birth Outcomes	$343,000
DHS-CHP	Family Planning Male Involvement		Reduce Unintended Pregnancies	$333,200
DHS-CHP	Fetal Alcohol Spectrum Disorder	To increase the number of women who completely abstain from drinking alcohol during pregnancy.	Improve Birth Outcomes	$327,260
DHS-CHP	Responsible Parenting	To delay subsequent pregnancy, monitor consistent and effective use of birth control, enable below post secondary school completion, provide information to help young parents improve parenting skills and cope with social and emotional problems related to pregnancy and parenting and to ensure the teen and her child are healthy and prepared for school, GED, tutoring services.	Improve Children's' Health	$153,000
DHS-CHP	Folic Acid Education	The goal is to make women aware of the importance of folic acid to fetal development and to encourage all women of child bearing age to take a multivitamin containing 400 micrograms of folic acid daily, in addition to eating a healthy diet.	Improve Birth Outcomes	$50,000

Health Services for Elderly

DOA	Community Care Program	Prevent unnecessary institutionalization of seniors 60+ by providing home and community services. Provides seniors with freedom of choice and a cost-effective alternative to nursing home placement.	Clients receive assistance with in-home services, adult day services, and emergency home response.	$553,006,400
DOA	Title VII LTC Ombudsman	Protect and promote rights and quality of life for residents in long term care	Complaints resolved to the satisfaction of the residents.	$1,000,000
DOA	Title III D Preventive Health	Provides federal funding for health promotion services for older adults.	Promotes health screening and health promotion services, and healthy life styles among older adults.	$1,000,000
DOA	Ombudsman Program			$351,900
DOA	Comprehensive Care Coordination	Comprehensive Care Coordination is a statewide holistic care management process for all individuals age sixty (60) or older who apply for older adult services or resources.	Services are identified that allow clients to remain in their own homes and live as independently as possible.	$40,885,700

Health Services for Children

DHS-CHP	Chicago MCH Services	The program's goals are to improve the health of women and children in Chicago and to ensure that medically indigent women and children receive health care.	Improve Children's' Health	$5,017,400
DCFS	HEALTH CARE NETWORK	Provides funding for the Department's Health Services Management Unit which coordinates and provides oversight regarding health services for all DCFS wards	Ensure quality health care; timely assessment of health needs; and documentation of health needs shared quickly	$4,072,500
DHS-CHP	Healthy Child Care Illinois	To promote positive development of children in childcare settings by linking families and child care providers to health services	Improve Children's' Health	$1,560,000
DHS-HCD	Children's Place	Services for HIV/AIDS affected families with children ages three months to five years.	Improved, family functioning, child development, respite for parents, medical needs	$656,600

DHS-CHP	Childhood Asthma	To identify children with asthma and refer them for diagnosis, treatment and other needed services. To educate parents and teachers of children with asthma regarding the reduction of asthma triggers in their environment. Recruit parents as “peer health educators” to assist in the education of more adults and children in school and communities regarding prevention and management of childhood asthma.	Improve Children's' Health	$240,000

HOUSING AND SHELTER

Overview

Safe, decent, affordable and integrated housing helps build economic security. The service delivery system for housing assistance includes a combination of federal, state and local resources. Federal assistance for those in need is primarily focused on providing actual housing units (such as through public housing) or subsidies that allow people to rent housing in the private market (such as the Housing Choice Voucher program).[1] Illinois's state programs focus on increasing housing stability for individuals and families, primarily geared toward serving those experiencing or at risk of homelessness. In addition to the state human services programs that are the focus on this report, it should be noted that additional services are available through the Illinois Housing Development Authority (IHDA).[2]

Most homeless providers in Illinois receive funding through a combination of four line items in the state budget that total just over $26 million annually – Homeless Youth, Homeless Prevention, Supportive Housing and Emergency and Transitional Housing. The programs and services funded through these line items include immediate shelter services to people experiencing homelessness as well as rental housing assistance and supportive services for both the recently homeless and for children and adults on the cusp of homelessness.

Stable, affordable and integrated housing is an issue under national attention as there is growing need in Illinois and across the United States. A range of housing programs and services – offering support to those experiencing homelessness, needing assistance to live independently, who have housing but are facing economic or other difficulties – are key to adequately addressing this basic human need.

For people with disabilities who want to transition out of nursing homes and live independently, Illinois has two community reintegration programs: Money Follows the Person (http://www.dhs.state.il.us/page.aspx?item=49837) and the Community Reintegration Program (http://www.dhs.state.il.us/page.aspx?item=37455). Centers for Independent Living, discussed in the Rehabilitative / Habilitative Services section of this report, are key community partners in the effort to provide people with disabilities the choice to live in the community.

The Illinois Housing Roundtable points out that housing development touches many lives beyond those needing a place to live. Housing: [3]

- Creates tax revenue – IHDA projects created $141 million in new state tax revenue in 2005
- Creates jobs – Housing construction means permanent jobs for contractors, architects, engineers, lenders, laborers and realtors

[1] Key sources of federal funding for housing and homelessness services include: McKinney Vento (which requires a match), Shelter Plus Care, Emergency Shelter Grants, Housing Choice Voucher (Section 8), and Public Housing funds,

[2] Specifically, the Rental Housing Support Program, administered by IHDA, provides rental subsidies to low-income families in private apartment buildings throughout Illinois. Funded through a fee associated with the sale of homes in Illinois, this program provides approximately 5,000 households with affordable housing every year. IHDA also provides housing counseling through collaboration with non-profit organizations. Additionally, and also outside of this report's scope, local housing resources largely connect to federal funding streams and consist of local housing authorities as well as emergency services.

[3] Illinois Housing Roundtable, *2008 Affordable Housing Briefing Book*.

- Stimulates the economy – Each dollar spent on residential construction generates $1.27 in additional economic activity.

- Helps business – Workers who live close to their jobs have lower rates of absenteeism and lower job turnover.

- Increases independence – Reduces reliance on the social service system and other emergency services by those experiencing homelessness.

In addition, research indicates that multiple housing factors, such as quality of housing, residential mobility and the surrounding neighborhood, all influence child and family wellbeing. These aspects of housing affect all three major areas of child well-being: physical health, social and emotional well-being, and cognitive development.[4]

According to the recent study done by the Chicago Alliance to End Homelessness and other housing groups, homeless service providers leverage over $80 million in federal funds each year that depend on a state match.[5] A proportionally smaller investment by the state translates into many dollars and the multiple outcomes listed above, all to the benefit of Illinois residents and communities

Individual and families with special needs often require service-enriched housing. A 2009 study by Heartland Alliance found that investments in supportive housing were cost effective and improved outcomes for participants, especially when compared to the cost of fragmented, reactive and crisis-driven interventions.[6] There was a 39 percent reduction in the total cost of services from pre- to post-supportive housing with an overall savings of $854,477 among a sample of 177 supportive housing residents over a two-year period. This was an average savings of $4,828 per resident for the two-year time period or $2,414 per resident, per year. In addition, providing supports so people with mental illness or other barriers can live in the community is significantly less expensive than housing them in a nursing home.

In addition to housing-specific services, other services utilized by people who are homeless or at-risk of homelessness go through other programs and state agencies. These programs are described in other sections of this report, such services for as individuals who are homeless and have mental health issues.

Populations Served

The DHS's Homeless Youth program specifically serves youth age 14 to 20 years who lack housing, lack the skills needed to live on their own without parents or who cannot return home. Homeless Prevention focuses on households that are in immediate danger of eviction, foreclosure or

[4] *How Housing Affects Child Well-Being*, Funders' Network for Smart Growth and Livable Communities, S. Vandivere, E.C. Hair, C. Theokas, K. Cleveland, M. McNamara, and A. Atienza, Fall 2006). Available at http://www.fundersnetwork.org/files/Housing_and_Child_Well_Being.pdf

[5] *A Devastating Impact: How More Budget Cuts and Delayed Payments Will Increase Homelessness in Illinois*, N. Amling, B. Palmer, D. Mueller, & L. Baker, (Chicago: Chicago Alliance to End Homelessness), March 2010. Available at: http://www.thechicagoalliance.org/documents/Budget percent20Survey percent20Report percent20Final.pdf

[6] *Supportive housing in Illinois: A wise investment*, A. Nogaski, A. Rynell, A. Terpstra, & H. Edwards. (Chicago: The Heartland Alliance Mid-America Institute on Poverty, April 2009.

homelessness or are currently homeless. The household must document a temporary economic crisis beyond its control and must be able to demonstrate an ability to meet the prospective rental/utility obligations after the assistance has been granted based on current or anticipated income. The Emergency and Transitional Housing and Supportive Housing programs serve persons who are homeless or at risk of homelessness.

Individuals and families in supportive housing include people who are homeless and people at risk of homelessness, due to serious and persistent issues such as mental illness and substance use. Supportive housing residents in Illinois report high rates of mental illness, drug and alcohol-related issues and previous incarceration. Over one in four are physically disabled.[7]

The populations using emergency and transitional housing are diverse. There are a number of catalysts to people ending up in emergency homeless shelters and many overlap. These include being chronically unemployed, working in low-wage jobs, having no or limited income, having a mental illness, having chronic health issues, being a single parent, being a substance user and not being able to find appropriate or affordable housing.

The annual number of people served by these programs is as follows: [8]

- Homeless Prevention: 2,500
- Supportive Housing: 8,500
- Homeless Youth: 1,127
- Emergency and Transitional Housing: 49,500, approximately one-third of whom are below the age of 18

Service Delivery System

Housing and shelter services in Illinois are largely provided by community-based nonprofit organizations. In most instances, services are provided to a specific geographic area. In the case of Supportive Housing and Emergency and Transitional Housing, local governments are often involved in providing services as well. Homeless Prevention Funds are provided through Illinois Homeless Services Continuum of Care. This is a network of local governments, community organizations and non-profit agencies that are geographically linked together to cover the service needs of the entire state. There are nearly seventy provider agencies, within twenty-one Continua of Care, working on homelessness prevention.

Illinois currently invests in housing and shelter services primarily in two areas:

1. Assisting families to maintain or regain stable housing in the face of a temporary crisis (as through the Homeless Prevention and Emergency and Transitional Housing programs). These programs together provide a mix of financial assistance, shelter, meals and other supports.

[7] H. Edwards, A. Nogaski, and A Rynell, "Study of supportive housing in Illinois: Interim report on publicly-funded service usage by residents prior to entry into supportive housing." Chicago: The Heartland Alliance Mid-America Institute on Poverty (August 2008).
[8] Data provided by the Illinois Department of Human Services.

2. Combining housing with support services for those needing a range of assistance (as through the Homeless Youth and Supportive Housing programs). These programs provide housing linked with case management, job services, counseling and other supports to help people maintain or attain independent living in the community.

Housing services are delivered in a combination of settings. The Homeless Prevention program is primarily a financial assistance program, with much of the case work happening over the phone or in a program office. Supportive Housing and Homeless Youth programs are often facility-based, with services and supports provided at a center and/or within the housing setting. There is also a subset of the Supportive Housing program that is provided through a scattered site model. Emergency and Transitional Housing is provided through shelters and local government entities.

Funding

According to FY 10 budget data provided by DHS, the department's four housing programs – Homeless Youth, Homeless Prevention, Emergency & Transitional Housing Program (formerly EF&S, [Emergency Food and Shelter]) and Supportive Housing – were funded at $26,095,610

These programs are primarily funded with state General Revenue Funds (GRF) making them particularly vulnerable to the budget shortfalls seen in recent years. Indeed, over the past several years, Illinois has cut funding for housing programs in the face of budget pressures.

The federal recovery act (ARRA) included time-limited funding for the Homelessness Prevention and Rapid Re-housing Program (HPRP). HPRP provides short- and medium-term rental assistance and services to either prevent individuals and families from becoming homeless or help those who are experiencing homelessness to be quickly re-housed and stabilized. Illinois received $70 million in HPRP funds. The majority of these funds, approximately $50 million, went directly to communities across the state. The Illinois Department of Commerce and Economic Opportunity (DCEO) is administering approximately $20 million of these funds in the Illinois State HPRP program. While the total dollar amount of these ARRA funds far outweighed what Illinois has had in place for homeless prevention previously and does target a new population, the end of ARRA funding will result in a sizable cut in the state's program.

Also of note, Illinois included $145 million in funding for affordable housing development and rehabilitation in its 2009 capital budget. This is an important investment in the development of affordable housing; however, none of these funds has yet been allocated. Also, without additional funds for supportive housing services, in addition to housing development, these capital funds will not benefit the chronically homeless.

As the chart below illustrates, state investments in housing programs over the past several years have declined, particularly for the Homeless Prevention program. It is important to note that state housing funds are often leveraged to draw down federal housing funding via community based agencies that are providing services, thus the impact of state budget cuts is far greater than the cuts alone would indicate. It is also important to note that proposed FY 11 amounts were current at the time of this report's writing, and may change.

State Budget Line Item	Previous High Funding Level	High Funding Year	FY10 Funding	FY11 Proposed Funding	$ Change High/ FY11P	% Change High/ FY11P
Emergency and Transitional Housing*	9,700.0	FY03	9,123.6	9,104.9	(595.1)	(6%)
Homeless Prevention Program	11,000.0	FY09	2,400.0	2,400.0	(8,600.0)	(78%)
Homeless Youth Program	4,747.7	FY08	3,622.0	3,259.8	(1,487.9)	(31%)
Supportive Housing Services^	21,347.5	FY10	21,347.5	21,347.5	0.0	0.0%
Total	**$46,747.5**		**$36,493.1**	**$36,112.2**	**($10,683.0)**	**(23%)**

Notes to chart:[9]
All dollar amounts are in thousands
* Formerly called the Emergency Food and Shelter Program.
^ Funds come from 2 line items: Mental Health Supportive Housing and Supportive Housing Services.

Critical Issues and Trends

The need for affordable housing and housing supports is growing, as is the scope of housing issues that significant portions of the population are experiencing. Multiple data sources suggest that housing affordability is increasingly a problem and that housing stability is being threatened for a growing number of Illinoisans, including middle and upper income home-owners. Yet, while demand for affordable housing is growing, the supply is shrinking. According to the Illinois Housing Roundtable, for every new affordable unit built, two are lost.[10] This is largely explained by a combination of decreasing supply of housing due to landlords who opt out of federal affordable housing programs, the demolition of public housing, gentrification and the decrease of affordable units.

According to the 2009 and 2010 Reports on Illinois Poverty:[11]

- As a result of the recession, approximately 34,500 additional Illinoisans may experience homelessness by the end of 2010, absent effective interventions[12]

- Seventy percent of low-income Illinois children are living in unaffordable housing, with their families spending over 30 percent of income on housing costs[13]

[9] *A Devastating Impact: How More Budget Cuts and Delayed Payments Will Increase Homelessness in Illinois,* March 24, 2010, *op cit*, page 4.
[10] Illinois Housing Roundtable, *2008 Affordable Housing Briefing Book*, *op cit*.
[11] Heartland Alliance for Human Needs and Human Rights, 2009 *Report on Illinois Poverty*, available at: http://www.heartlandalliance.org/povertyreport/2009-report-poverty.html
[12] Social IMPACT Research Center's analysis of National Alliance to End Homelessness, *Homelessness looms as potential outcome of recession*. Washington, DC, January 15, 2009.
[13] Annie E. Casey Foundation, *2008 Kids Count data center*. Retrieved January 22, 2009, from http://www.kidscount.org/datacenter/databook.jsp

- Illinois had the 9th highest foreclosure rate in the nation in 2008, with foreclosures up 54.7 percent since 2007.[14] Only nine states had a greater proportion of homes that received a foreclosure filing in March 2010 than Illinois, in which one out of every 371 homes received a foreclosure filing.

According to a report from the Chicago Alliance to End Homelessness, agencies are turning people in need of housing away. Sixty-one agencies turned away 1,292 people in January 2010 because of prior year state budget cuts, representing nine percent of the 13,720 people they were able to serve. This does not include additional people who were turned away for issues not related to state budget cuts, such as lack of bed space. [15]

Families living "doubled up" can obscure the actual number of families experiencing housing challenges.[16] According to the Regional Roundtable on Homelessness, more than two in five people experiencing homelessness in the Chicago region report living doubled up before becoming homeless. Data from the late 1990s indicate that approximately five percent of households in the region are doubled up.[17]

According to the Illinois Housing Roundtable, 1.5 million Illinois households pay more for housing than federal guidelines recommend. A staggering 722,000 households in Illinois pay more than 50 percent of their income for housing. Federal guidelines say that no one should spend more than 30 percent of their income on housing—including rent or mortgage payments, utilities, property taxes and insurance. However, one in every four Illinois households are paying more than half of their income for housing.[18] Further, according to the National Low Income Housing Coalition, there is no place in Illinois where a family making minimum wage can afford fair-market rent on a two-bedroom unit.[19]

It is important to note the range of housing options needed within a housing system that is adequate to meet the needs of diverse consumers, ranging from temporary emergency assistance to long-term affordable or supportive housing placement. Effectiveness of an intervention with the target population, ability to meet diverse needs as well as cost effectiveness must be considered when reviewing or designing a system that aims to be comprehensive. For example, there are not enough harm-reduction housing slots to meet the need, particularly for people experiencing homeless who are dually diagnosed with a mental illness and substance use issues. In addition, over the past decade federal priorities have shifted away from shelters and supportive services to focus more on housing first interventions. While the emphasis on housing is key to ending homelessness, so are the services that help people stay housed, access benefits and employment and participate in treatment. Funding for services has weakened despite the great need.

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[14] Realty Tract. (2009, January 15). *Foreclosure activity increases 81 percent in 2008*. Retrieved January 15, 2009, from http://www.realtytrac.com/ContentManagement/pressrelease.aspx?ChannelID=9&ItemID=5681&accnt=64847

[15] Amling, N., Palmer, B., Mueller, D., & Baker, L. (2010, March). A Devastating Impact: How More Budget Cuts and Delayed Payments Will Increase Homelessness in Illinois. Chicago: Chicago Alliance to End Homelessness.

[16] "Doubled up" describes a situation in which people are temporarily living with relatives or friends, often in overcrowded conditions, due to the loss of their previous home. It is one of the strongest predictors of homelessness.

[17] Smith, J. and Rynell, A. (Ed). Facing Homelessness: A Study of Homelessness in Chicago & the Suburbs. Regional Roundtable on Homelessness. November 2002.

[18] Social IMPACT Research Center's analysis of the U.S. Census Bureau's 2008 American Community Survey.

[19] National Low Income Housing Coalition, *Out of Reach 2010*. Washington, DC. Available at: http://www.nlihc.org/oor/oor2009/data.cfm?getstate=on&state=IL

Finally, where there is limited access to adequate housing and shelter, it often results in increased use of other government systems at increased cost. Some argue that it costs the state significantly more to house someone in a nursing home or in the corrections system than to provide supportive, subsidized housing and services that allow individuals who are able to live independently in the community. While there are contrary viewpoints on the cost-effectiveness of institutional or facilities-based housing versus home or community based care, policy priorities at the state and federal level – including deinstitutionalization and the Olmstead decision – emphasize housing people in the least restrictive environments possible, prioritizing community care over institutionalization.

Human Service Category: Housing and Shelter

Data Source: State agencies as indicated in the first column

Shelters and Supportive Housing for the Homeless

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DHS-HCD	Supportive Housing	Provide supportive services to persons who are homeless, formerly homeless or at imminent risk of becoming homeless and residing in permanent or transitional housing.	Reduce the number of persons that are experiencing homelessness. Helps individuals return to self-sufficiency.	$10,307,548
DHS-HCD	Emergency & Transitional Housing Program (formerly EF&S)	Provide food, shelter and supportive services to persons who are homeless or at imminent risk of becoming homeless.	Immediate and comprehensive shelter services which will decrease the number of persons living on the streets.	$9,766,062
DHS-CHP	Homeless Youth	The purpose of the Homeless Youth program is to provide services that help homeless youth transition to independent living and become self-sufficient. The program strives to meet the immediate survival needs of youth (food, clothing, and shelter) and assist them in becoming self-sufficient.	Safety and Self Sufficiency	$3,622,000
DHS-HCD	Homeless Prevention	Provide rental/mortgage assistance; utility assistance and supportive services directly related to the prevention of homelessness or repeated episodes of homelessness.	Stabilize individuals and families in their existing homes, shorten the amount of time that individuals and families stay in shelter and assist individuals and families with securing affordable housing.	$2,400,000

INDIVIDUAL AND FAMILY SUPPORT

Overview

A major area of the human services system consists of time-limited supportive services that the state provides to individuals and families facing specific needs, vulnerabilities and dangers at critical points in their life.

Infants and very young children who need a strong start to life and learning; victims of domestic violence and sexual assault, young people suffering from abuse or severe behavior problems, or who are challenged by becoming parents at a very young age, immigrants and refugees coping with resettlement and people facing growing frailties at the end of life are all examples of individuals and families experiencing emergent or expected needs that are time-limited and critical.

The Department on Aging (DOA), Department of Human Services (DHS), Board of Education (ISBE) and Department of Children and Family Services (DCFS) are the primary agencies that fund and oversee these types of programs. Taken together, these agencies budgeted over $2.47 billion for individual and family support services in FY 10, according to data provided by the four agencies.

Given the large number and diverse foci of these programs, they are organized under the following areas:

- Early Childhood Education, Development and Parenting
- Child Welfare
- Youth Development and After School Programs[1]
- Juvenile Delinquency / Violence Prevention
- Domestic Abuse, Sexual Assault and Elder Abuse and Neglect
- Senior Services
- Immigrants and Refugees

Under each area, this section covers the same set of topics found elsewhere in the report: overall purpose and goals, populations served, service delivery system, funding and critical issues and trends, with an emphasis on major programs.

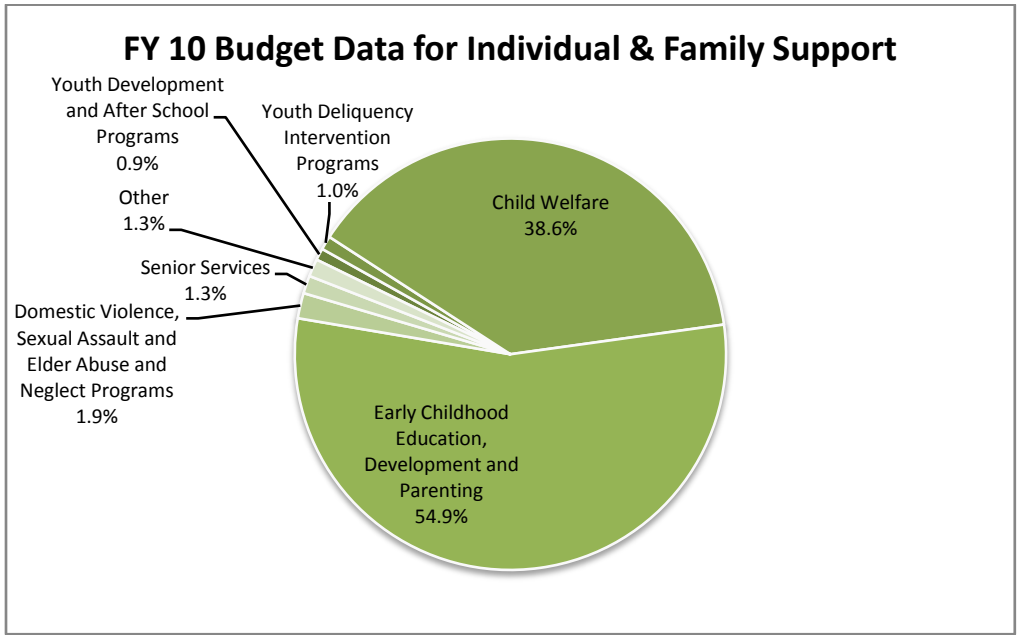
FY 10 budget data provided by state agencies show the following breakdown for individual and family support services:

[1] This human services area includes four programs that target youth development and after-school programs, the largest of which are Teen REACH and After School Matters. Time and resource constraints prevented development of a full discussion of them here; however, the table at the end of this section offers funding details, as well as a summary of each program's purpose and key outcomes. The reader will find additional details at the following sources: http://igpa.uillinois.edu/system/files/AfterSchoolinIllinoisArticle_Appendix.pdf and http://www.cprd.illinois.edu/files/TRBenchmarks04.pdf

FY 10 Budget Data for Individual and Family Support

	Total
	$ 2,472,003,176
Youth Development and After School Programs	$ 22,172,700
Youth Delinquency / Violence Prevention	$ 25,582,110
Child Welfare	$ 955,381,400
Early Childhood Education, Development and Parenting	$ 1,356,459,885
Domestic Violence, Sexual Assault, Elder Abuse & Neglect	$ 46,957,100
Senior Services	$ 33,005,300
Other	$ 32,444,681

These numbers are visually illustrated in the following chart:



EARLY CHILDHOOD EDUCATION, DEVELOPMENT AND PARENTING

Overview: Although child care and early education services were once treated as separate activities, it is now recognized that they should be offered together. Illinois has become a pioneer state in realizing the connection between child care and early education and treating them as one industry, called the Early Childhood Care and Education (ECE) system.

The goals of the ECE system are to 1) support low-income families in attaining self-sufficiency by subsidizing child care while parents are at work or in school and 2) improve developmental outcomes of

young children being cared for outside the home. ECE in Illinois is provided in a wide variety of settings and program models, ranging from informal care by relatives and neighbors to school-based programs. Public support for these services is provided through three primary funding streams: the Child Care Assistance Program (a DHS program), the Early Childhood Block Grant (an ISBE program) and Head Start & Early Head Start (a federal program).[2] Each of these funding streams has its own eligibility criteria and program requirements that grow out of distinct goals of the department.

In addition to the three primary funding streams, ECE in Illinois is enhanced through collaboration with other programs – including include Parents Too Soon & Teen Parent Services, Early Intervention, Migrant Head Start, and Crisis Nurseries – and two systems-building initiatives – All Our Kids (AOK) Networks and Strong Foundations – all of which are covered in this discussion.

The Child Care Assistance Program

Overview: DHS administers the Child Care Assistance Program (CCAP). Its purpose is to ensure that 1) low-income parents have access to affordable child care so they can remain in the workforce or school and, 2) families have access to high-quality early care and education, regardless of family income or geographic location. In addition to supporting families, CCAP funds enhancements to improve the quality of child care available in Illinois and to support child care practitioners through technical assistance, professional development opportunities and other resources.

Funding: CCAP is funded by the federal Child Care and Development Fund (CCDF), Temporary Assistance to Needy Families (TANF), and the general revenue fund (GRF). According to data provided by DHS, in FY 10 CCAP was budgeted at just over $777 million, from a mix of these sources. In addition, Illinois received $74 million in a supplemental allocation to the federal CCDF appropriation through the American Recovery and Reinvestment Act (ARRA). In FY 09, the CCAP state appropriation cut about $1.9 million for the Great Start program (wage supplements for child care practitioners). State funding stayed at that lower level in FY 10.

Populations served: CCAP serves children of low-income working families from birth through 13 years and children with special needs ages 13 through 19. It is important to note that CCAP funding is not exclusively for children ages birth to five: approximately 40 percent of the CCAP caseload consists of school-age children needing after school care.

Families are eligible to participate if their income is below 200 percent of the federal poverty level (FPL, $36,620/year for a family of three). In FY 09, CCAP served an average of 164,304 children each month (87,000 families), of which approximately 60 percent are under six years of age and 40 percent are school-age. To qualify for CCAP, parents are required to be employed or enrolled in an approved education or training program. In FY 08, 91 percent of the parents using CCAP were employed. All eligible families applying for CCAP received services and no waiting lists were instituted.

[2] While it is outside of the scope of this report, it is important to note that Head Start and Early Head Start are critical components of the early care and education system in Illinois. Administered by the federal Administration on Children and Families (Office of Head Start), Head Start and Early Head Start provide high quality comprehensive services which include educational, health, nutritional, and family support services to low-income pregnant women and children birth to five. Services are provided through community-based agencies in both center-based and home-based programs to families whose income is below 100 percent of the federal poverty level (FPL). In Illinois, Early Head Start served 2,725 infants and toddlers in FY 09 and Head Start served 39,435 preschoolers.

Service Delivery System: CCAP allows parents to select a child care provider that meets their needs, including licensed child care centers, licensed family child care homes and group homes, as well as license-exempt centers and license-exempt family child care settings that accept child care subsidies. The child care provider is reimbursed at the established state rate, which varies depending on the type of provider, the age of the child, and the region of the state (the state is divided into three regions). All families that participate in CCAP make a state-assessed co-payment to their provider.

In addition to providing child care subsidies, CCAP allocates funds to improve child care quality in Illinois. DHS does this by contracting with sixteen Child Care Resource and Referral (CCR&R) agencies across the state as well as funding resources and training for child care providers. CCR&Rs handle CCAP eligibility determination for parents that qualify for child care assistance as well as the payment process to child care providers. CCR&R specialists provide parents with consultations, consumer education, child care referrals and assistance with completing paperwork. CCR&Rs support child care providers through technical assistance, professional development and other services aimed at building professionalism and educational attainment for child care providers, including in-service training to maintain state licensing and grants to expand capacity and increase quality in child care programs. CCAP also funds Great START (Strategies to Attract and Retain Teachers), a wage supplement program that offers financial incentives to providers who have attained education beyond state licensing requirements and who remain employed by the same child care program.

CCAP also funds specialized consultants who work with child care providers to help them meet the needs of the children they serve. The Healthy Child Care Illinois (HCCI) program links child care programs to nurse consultants for guidance and assistance on issues affecting the health and safety of children. Mental health consultants work with providers on recognizing, understanding and responding to the social emotional needs of the children in their care. Infant toddler specialists provide curriculum consultations, current infant toddler practice trainings, site evaluations, resources for meeting state guidelines and strategies for understanding and working with infants and toddlers.

The Early Childhood Block Grant

Overview: ISBE's Early Childhood Block Grant (ECBG) funds Preschool for All (PFA; or prekindergarten [pre-k] for children three to five years old) as well as services for at-risk infants, toddlers and their families.

PFA provides voluntary, part-day pre-k for three- and four-year-olds whose parents choose it, while prioritizing children who are at-risk. PFA employs high-quality curricula and teaching staff in a variety of settings that parents choose (schools, child care, other community-based providers). This addresses the shortage of school-based classrooms as well as some families' need for full-day/full-year care. PFA includes funding for training, technical assistance and mental health consultation for teachers, efforts to expand the supply of certified teachers, monitoring and accountability and a statewide program evaluation.

ECBG also provides research-based, comprehensive prevention services for at-risk expecting parents and families with children ages birth to three years through the Prevention Initiative (PI). The aim of PI is to provide early, continuous, and intensive child development and family support services to help families build a strong foundation and prepare children for later school success.

Funding: ECBG was created in 1986 by combining three preexisting funding streams for programs available to infants, toddlers and preschoolers. ECBG, supported entirely with GRF dollars, has a mandatory funding set-aside for infant and toddler programs, requiring increases in infant and toddler services as preschool funding grows. Since 1990, ECBG funding has grown from $48 million to over $342 million in FY 10, with the most significant gains occurring since FY 04. However, in FY 10 its budget was cut by 10 percent. Of late, ECE providers, like others in the human services system, face difficulties making payroll, paying rent and other financial hardships due to late payments.

Populations served: ECBG serves children birth to age five. By statue, infant and toddler programs are targeted to children who are at-risk, and programs must implement an approved research-based model for providing services. Before FY 07, services for three- and four-year-olds were provided by the Prekindergarten at Risk program, serving just those preschoolers who met the local definition for risk of school failure. With the passage of PFA in FY 07, programs that do not primarily serve at-risk children are also able to apply for funding. An "at-risk first" approach is used to award funding. The definition of at-risk is determined locally, using indicators such as high levels of poverty, illiteracy, unemployment, and limited-English proficiency.

In FY 09 more that 95,000 preschool children were served by ECBG, up from the more than 16,000 children who were served in block grant-funded infant and toddler programs in FY 07. Although the block grant had experienced significant growth prior to FY 10, demand still far outstrips funds. In FY 08, more than 17,000 children were reported on waiting lists for preschool programs (this is likely an underestimation, as not all programs report waiting lists to the state). Unmet demand for infant and toddler programs is also great: ISBE was only able to fund about six percent of the applications it received for infant and toddler services in FY 08.

Service Delivery System: Preschool for All is provided to three- and four-year-olds by public schools and community agencies in both full-day, full-year and school–day, school-year settings Public schools, non-profit and for-profit child care centers, community-based organizations, Head Start agencies, and charter schools are examples of entities that can apply, through a competitive grant process, to provide block grant services.

Since FY 06, programs serving infants and toddlers are required to use a research-based program model in order to receive ECBG funding. Funding can be used to enhance center-based services or to provide parent coaching and infant development activities through home visiting services.

<u>Migrant Head Start</u>

Migrant Head Start serves migrant children and their families who travel to Illinois to plant, harvest and process agricultural products between the months of April and December. It was budgeted at $3.2 million for FY 10, has been flat for several years, but experienced an increase in federal funding in the last fiscal year due to ARRA. Service providers are located in areas of migrant concentration and serve current migrant families and those who have settled out within the past 24 months. This program served 470 children in FY 09.

As previously noted, the ECE system in Illinois includes the following "collaborating programs":

<u>Parents Too Soon and Teen Parent Services</u>

Overview: DHS administers a Parents Too Soon (PTS) program that serves new and expectant teen parents living in high-risk communities. Its goals are to teach effective parenting techniques, improve the health and emotional development of teen mothers, enhance self-sufficiency and promote healthy growth and development of their children. Services are voluntary and include weekly home visits and peer-group meetings.

DHS also administers Teen Parent Services (TPS). The goals of the program are to increase below post secondary school completion, reduce subsequent unplanned pregnancy, improve parenting skills, and increase the rate of immunizations, well baby visits and screening for developmental delays. Services include assessment, service plan, development and delivery to alleviate barriers to self sufficiency and good parent and child health to ensure school readiness.

Funding: PTS and TPS programs were cut by 10 percent and 18.5 percent, respectively, in FY 10.

Populations served: PTS and TPS programs serve pregnant and parenting adolescents in high-risk communities. PTS determines clients' risk during the recruitment process and enrolls the highest-risk clients into the program, usually prenatally or in the early months of a child's infancy. Over 2,000 families were served by PTS in FY 08. This is a fraction of those who could benefit as, in any given year, about 108,000 infants and toddlers under three are at-risk of poor development and school failure. Unfortunately, current funds for home visiting only allow Illinois to serve less than seven percent of these at-risk children.

For TPS, eligible adolescents are younger than 20 years old, have not completed high school or a GED program and are low income. TPS is mandatory for teens receiving TANF. A related program, Teen Parent Family Services, serves the partners or siblings (over age 15) of the pregnant and parenting adolescents who receive services through the TPS Central Office. TPS served almost 10,000 clients in FY 08, and Teen Parent Family Services provided services to almost 100 clients.

Service Delivery System: PTS is provided by community-based and/or non-profit agencies. Evidence-based home visiting services are provided in Cook and 15 other counties throughout Illinois. In-home "parent coaches" work with families on a voluntary basis – from pregnancy through the first three years of a child's life – to support early learning and healthy development and to prevent child abuse. TPS is available through 88 local health departments, community-based organizations, community colleges and two IDHS staffed offices. The program offers case management, counseling, assistance with GED or high school completion and parenting instruction. The family services component focuses on assisting clients with attaining educational and employment goals.

<u>Early Intervention</u>

Overview: Established through the Individuals with Disabilities Education Act part C and administered by DHS, Early Intervention (EI) is designed to ensure that children from birth to age three with diagnosed developmental delays or risk of delay get timely, appropriate services. In FY 09, EI's funding was increased by 10 percent, followed by cuts of almost 10 percent the following year. Because this program is a federal entitlement, providers must continue to provide services to all children who are determined eligible.

EI serves children under the age of three who have a measurable developmental delay of 30 percent below age-appropriate standards in one or more developmental areas or who have a physical or mental

condition that typically results in developmental delay. The program served over 21,000 families in FY 08. EI services are provided to children in their homes. Services include developmental physical, occupational and speech therapies as well as nutrition, social and emotional services. A recent analysis of EI caseload and expenditures for FY 02 through FY 10 revealed that the number of infants and toddlers with Individual Family Service Plans has increased by 80.3 percent, while spending for EI increased by 32.2 percent.

Crisis Nurseries

Crisis Nurseries are administered by DHS to provide 24-hour support and child care to families in crisis in order to assist them in stabilizing their family situation. Funding for them was reduced in FY 10 to $42,900.

Crisis Nurseries served 550 children under six years of age and their families in FY 08, providing provide services to high-risk families to increase stability, reduce the risk of child abuse and neglect and prevent families from entering the foster care system. Families may be in crisis due to violence, family dysfunction, medical emergencies or lost employment. Six non-profit agencies operate crisis nurseries in Illinois, providing round-the-clock care in a licensed facility for children under six when a family is in crisis. Once a crisis has stabilized, families participate in home visits, parenting classes and counseling, and receive referrals to other community services. All services are provided in center-based facilities.

Finally, two "systems-building initiatives" are part of the ECE network in Illinois:

All Our Kids Network

The All Our Kids (AOK) Early Childhood Network is a collaborative effort between DHS (Maternal & Infant Health Bureau and Child Care Bureau), ISBE, local health departments, family members and other local agencies serving very young children and their families. The overall goal is to ensure that all children under age five and their families have the opportunity to receive services they need, from prenatal care to parenting education to specialized services, such as speech therapy, physical therapy or home visits. Funding for AOK was reduced to just over $1 million in FY 10.

AOK networks do not provide direct services; rather, they convene stakeholders at the community level to increase the quality and coordination of services to pregnant women and all families with a child under age five within each network community. AOK Networks are administered through 11 local health departments, one Regional Office of Education and one local Early Childhood Collaborative, with DHS providing coordination.

Strong Foundations Initiative

Strong Foundations, a federal grant focused on building infrastructure for evidence-based home visiting programs for infants and toddlers, is being implemented by DHS in collaboration with ISBE and DCFS. Strong Foundations supports three evidence-based models of home visitation: Parents as Teachers, Healthy Families America, and the Nurse-Family Partnership. Currently in year two, Strong Foundations was envisioned as a five-year project. However, federal funding was not appropriated as expected in the third year and all states experienced significant reductions in their funding. As of this writing, it is expected that Strong Foundations will be replaced by a major early childhood home visiting initiative in the new Patient Protection and Affordable Care Act (health care reform).

While Strong Foundations does not provide direct services, it supports programs that serve pregnant women and children aged birth to three.

Critical Issues and Trends (in ECE Overall): Illinois has been recognized as a national leader in early childhood education and care and has worked across agencies to move toward high quality for all children served. As noted throughout this discussion, most the programs in this area serve low-income families. The demand for programs is likely to grow as the number of families living in poverty grows. The poverty rate for Illinois children under age 6 is 20 percent, the highest for any age group, and the most recent data does not yet reflect the full impact of the current recession. Based on patterns of past recessions, the nationwide child poverty rate is projected to exceed 24 percent in 2012. If trends in Illinois follow these projections, the child poverty rate in Illinois can be expected to reach about 22 percent, affecting over 650,000 children.

Research links high-quality early childhood programs to both school success and improved social-emotional outcomes for children. Leading economists have concluded that early investments in human capital are the most cost-effective strategy for improving outcomes for individuals and society as a whole. They estimate that every dollar spent on high-quality early education society saves seven dollars in future costs for special education, delinquency, crime control, public assistance benefits, lost taxes and other areas.[3]

The child care service delivery system is diverse and generally underfunded. Since low income families must be working or in an education or training program to qualify for child care subsidies, the economic downturn is having an impact on many families: lost jobs translate to lost child care and lost early childhood development opportunities for their children. Additionally, more and more low-wage workers are employed in jobs with non-standard work schedules. Parents who work alternating or second- or third-shifts have difficulty accessing services as most programs provide care during typical work hours.

New and proposed initiatives at both the state and federal levels have helped focus attention on home visiting programs, especially for children and families who are at risk. Research suggests that evidence-based home visiting programs such as PTS, Healthy Families and ECBG can improve the quality of life for our youngest citizens and, over time, yield significant returns in reduced mental health and criminal justice costs, decreased dependence on welfare and increased employment. Families that have the opportunity to develop parenting skills can help their children get the best possible start in life.[4]

All of these programs primarily serve families with young children (and CCAP serves school-age children as well). One key demographic trend is the growth in the number of families needing services whose primary language is not English. Service providers often struggle to provide culturally and linguistically appropriate services for their clients. According to ISBE program statistics, Latino participation in ECBG preschool programs has grown from 16 percent of children served in FY 90 to 30 percent in FY 08.

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[3] Ramey, C., Campbell, F., & Blair, C. (1998). "Enhancing the life course for high-risk children," in J. Crane (Ed.), *Social programs that work* (New York: Russell Sage Foundation, 1998), pp 184 – 199. [Note: Additional statistics cited on the Abecedarian Project's Web site at http://www.fpg.unc.edu/verity/] and Heckman, James J. (2008). "Schools, Skills and Synapses," *Economic Inquiry*, 46(3): 289-324.

[4] Chambliss, J. & Emshoff, J. (1997). The Evaluation of Georgia's Healthy Families Programs; Katzev, A., Pratt, C., & McGuigan, W. (2001), Multisite Parents as Teachers Evaluation: Experience and Outcomes for Children and Families; Administration for Children and Families (2003), *Research to Practice: Early Head Start Home-Based Services,* Washington, DC: DHHS, .acf.hhs.gov/programs/core/ongoing_research/ehs/ehsintro.html.

Another population-related issue is that homeless families often get left out of the service delivery and priority population system because of where they are residing.

Because EI is a federal entitlement program, it is required to serve all children who qualify for services. However, there are not enough providers to serve children in many less populous areas of the state and it can be difficult to match a child with a provider who speaks his or her home language. Through work done in several initiatives in early childhood programs and primary medical settings, Illinois is doing a better job providing developmental screening for young children. More children with delays are being identified. Earlier detection yields improved outcomes for young children but with increased caseloads, EI is experiencing further stresses on an already challenged system.

CHILD WELFARE

Overview: DCFS administers programs to address the needs of children and families facing the potential or actual separation of a child or adolescent from his or her parents through a court order because of abuse, neglect, child behavior or dependency.

Another way to state this is that these programs protect children from harm. These programs then provide substitute care and prepare for the reunification of child and parent, if that is the goal, or arrange for the permanent non-parental care of the child, through adoption or subsidized guardianship. In some cases, youth remain in the custody of DCFS until adulthood.

Providing substitute care means addressing all of the permanency, safety, and well-being needs of the child; it addresses the needs of the parent to a lesser extent, but in recent years, great strides have been made in addressing the substance abuse of parents. DCFS also provide services to intact families—those in which children still live with parents in the home where a substantiated report of abuse or neglect was made—in order to address and monitor the circumstances that led to the report.

Populations served: The number of indicated child victims of abuse or neglect has been stable since 2001 at between 26,000 and 30,000 per year. The number of child victims in Cook County has decreased from 10,000 in 2001 to around 8,000 per year for the past three years. In part this is due to more children being adopted or taken into subsidized guardianship by relatives. The rest of the state has shown an increase from about 19,000 in to nearly 22,000 in 2009.

The total child and family caseload--those children and families that are being served-- in Illinois has decreased by about 1500 cases to a level of 23,822 in the past five years. In the past five years, the caseload in Cook County has dropped by about 3,000 cases, while the caseload in the rest of the state has increased by about 2,000 cases. There were over 100,000 children in DCFS cases (family cases have multiple children in them) in the mid-1990s and now there are slightly over 50,000. In the mid-1990's, over 5,000 of these children were in congregate settings. Private agencies and the state system developed new models; and today only approximately 1,300 children are in congregate settings, making this an example of a successful shift from institutional to family / community based care. The next table, provided by DCFS for this report, summarizes caseload history according to that agency's records. It shows that the total substitute care caseload has decreased by 50 percent since FY 2000. Except for independent living, which is an option for older youth, all types of placements have decreased by about 50 percent.

SUBSTITUTE CARE CASELOAD HISTORY

Fiscal Year	Foster Care				Residential Placements		Independent Living		Total Substitute Care	
	Home of Relative	Specialized	Regular	TOTAL						
Caseloads										
FY 00	12,454		5,907		8,868		27,229		2,470		968		30,667	
FY 01	10,174		4,324		8,896		23,394		2,293		933		26,620	
FY 02	8,534		4,137		7,665		20,336		1,998		899		23,233	
FY 03	6,989		3,934		7,095		18,018		1,658		975		20,651	
FY 04	6,596		3,493		6,597		16,686		1,505		909		19,100	
FY 05	6,556		3,339		6,083		15,978		1,378		884		18,240	
FY 06	6,189		3,494		5,287		14,970		1,361		929		17,260	
FY 07	5,867		3,219		4,825		13,911		1,257		946		16,114	
FY 08	6,187		3,213		4,479		13,879		1,343		858		16,080	
FY 09	5,984		3,191		4,409		13,584		1,348		769		15,701	
FY 10est	6,116		3,058		4,121		13,295		1,355		805		15,455	
Yr. to Yr. Caseload Change														
FY 01	(2,280)	-18.3%	(1,583)	-26.8%	28	0.3%	28	0.3%	(177)	-7.2%	(35)	-3.6%	(4,047)	-13.2%
FY 02	(1,640)	-16.1%	(187)	-4.3%	(1,231)	-13.8%	(3,058)	-13.1%	(295)	-12.9%	(34)	-3.6%	(3,387)	-12.7%
FY 03	(1,545)	-18.1%	(203)	-4.9%	(570)	-7.4%	(2,318)	-11.4%	(340)	-17.0%	76	8.5%	(2,582)	-11.1%
FY 04	(393)	-5.6%	(441)	-11.2%	(498)	-7.0%	(1,332)	-7.4%	(153)	-9.2%	(66)	-6.8%	(1,551)	-7.5%
FY 05	(40)	-0.6%	(154)	-4.4%	(514)	-7.8%	(708)	-4.2%	(127)	-8.4%	(25)	-2.8%	(860)	-4.5%
FY 06	(367)	-5.6%	155	4.6%	(796)	-13.1%	(1,008)	-6.3%	(17)	-1.2%	45	5.1%	(980)	-5.4%
FY 07	(322)	-5.2%	(275)	-7.9%	(462)	-8.7%	(1,059)	-7.1%	(104)	-7.6%	17	1.8%	(1,146)	-6.6%
FY 08	320	5.5%	(6)	-0.2%	(346)	-7.2%	(32)	-0.2%	86	6.8%	(88)	-9.3%	(34)	-0.2%
FY 09	(203)	-3.3%	(22)	-0.7%	(70)	-1.6%	(295)	-2.1%	5	0.4%	(89)	-10.4%	(379)	-2.4%
FY 10 est	132	2.2%	(133)	-4.2%	(288)	-6.5%	(289)	-2.1%	7	0.5%	36	4.7%	(246)	-1.6%

Service Delivery System: Suspected cases of abuse or neglect are reported to the DCFS through a statewide hot line. Reports can be made by anyone, although certain professionals – including doctors, teachers and school personnel, child care workers – are mandated reporters.

Through established criteria, hotline operators decide whether an abuse or neglect report should be recorded and investigated. These investigations are carried out by DCFS investigators, who determine whether there is credible evidence of abuse or neglect. The investigator decides whether the children in the family must be removed immediately from the custody of their parents for their own safety and placed into foster care and the protective custody of DCFS. When this occurs, a child will be placed with a relative, foster parent or an institutional under court order. It is important to note that the courts decide whether a child is placed in foster care and when a child is allowed to return to the custody of his or her parents or placed in another permanent situation with adoptive parents or other guardians. Relatives provide about one-half of the foster care, while unrelated individuals provide the rest. If children are not immediately removed from the home, other DCFS workers decide what protective services might be provided to the family.

Although state employees investigate child maltreatment and manage some foster care cases, most cases are managed by private agencies and most services are provided by private agencies. Private agencies also provide residential care and mental health services. DCFS personnel oversee and monitor all providers of out-of-home care.

It is important to note that while children are in the custody of DCFS, all of their needs must be addressed. The department must facilitate their educational progress. Each child is to have an educational advocate in addition to a foster parent. The goal of the department is to have every three and four year-old in a high quality early childhood program. These children must receive adequate health care. (Many did not receive proper health care while living with biological parents.) All new cases of foster care receive extensive assessments in order to determine what additional services the child and family may need. This activity, called Integrated Assessment, is a model program in the United States, and is the core of determining what services a child needs in order for the department to ensure a child's well-being.

Funding: As outlined above, DHS child welfare programs were funded at $955,381,400 in FY 10.

Critical Issues and Trends: The child welfare system has made major progress in recent years and faces major challenges today. First, there are a number of administrative and budget challenges. DCFS is seeking to increase federal revenue. Options include increasing the licensure of relative foster homes to increase Social Security Act Title IV-E funding. Cost control is another challenge, and so the system is likely to look at ways to reduce utilization of institutional and group home care, as these are the most costly form of foster care (for reasons that include the cost of licensure). DCFS is using performance contracting strategies to control the costs of institutional care. Securing needed funds to address the mental health of all children in foster care is another significant challenge.

From a practice perspective, DCFS has focused on addressing the trauma that children experience. They have begun Learning Collaboratives across the state to train both public and private frontline practitioners on the importance of "psychological first aid" and assessing the assets, needs and strengths of children.

Other policy and practice issues focus on strengthening families. A number of initiatives are being put into place that, if successful, may lead to smaller foster care caseloads and better outcomes for families whose children are in foster care. These initiatives include Strengthening Families, which seeks to enlist parents in distressed communities to come together to improve parenting. Family Advocacy Centers are being created across the state to assist parents in addressing the needs of their children, whether the children are in foster care or not.

Lastly and obviously, a critical issue is the potential merger of DCFS and DJJ, because it raises issues of what the priorities are relative to the two populations of abused and neglected children and delinquent children. It is clear that there is significant overlap among these two populations. Many incarcerated youth have been abused or neglected and some foster wards will come to the attention of DJJ.

YOUTH DELINQUENCY / VIOLENCE PREVENTION PROGRAMS

Overview: DHS funds a set of juvenile delinquency and violence prevention programs that address delinquent or criminal behavior on the part of a child or adolescent. These programs seek to divert youth from initial or further involvement in the criminal justice system and they protect the community from delinquent behavior.

Populations served: According to figures provided by DHS, these programs serve over 56,000 youth who have had some contact with the justice system, a figure that may include duplicate cases. Information on the nature of the risks and challenges these children face is described in the program summaries, below.

Funding: According to FY 10 budget data provided by DHS, these programs were funded at $25.6 million.

Service Delivery System: Research has found that non-violent youth are less likely to become further involved in criminal behavior if they remain in their home communities and appropriate services are available that address underlying needs such as mental illness, substance abuse, learning disabilities, unstable living arrangements and dysfunctional parenting. DHS spends tens of millions of dollars annually on prevention and diversion community-based programs designed to accomplish this.[1] County-run, but state-funded Probation departments also provide both rehabilitative services and supervision. DHS programs include the following:

- Comprehensive Community Based Youth Services (CCBYS): provides short-term crisis intervention to runaways, children whose parents refuse to care for them and youth who are beyond the control of their parents. Services are offered throughout the state on a 24-hour-a-day basis.

- Communities for Youth: reaches youth who are involved in risk-taking behavior (such as gangs, drug, or violence), who have been station adjusted, or who are on probation and offers diversion and intervention programs.

- Delinquency Prevention: youth who are referred by law enforcement or probation and have committed a delinquent offense are provided diversion services, such as outreach, advocacy,

[1]Other state programs to meet the multiple service needs of delinquent youth and youth that have had contact with the Juvenile Justice system are described under the Criminal Correctional System section of this report.

individual and family counseling, intake assessment, employment and recreation, to avoid deeper involvement in the justice system.

- Redeploy Illinois: gives counties financial support to provide comprehensive services to delinquent youth in their home communities who might otherwise be committed to DJJ. Unfortunately, many Illinois counties lack the resources to effectively serve delinquent youth locally. A lack of local programs and services plays a significant role in a court's decision to commit a youth to a youth facility. The funds provided to the Redeploy pilot sites fills the gaps in their local continuum of services, in order to reduce the system's reliance on the correctional system.

- Unified Delinquency Intervention Services (UDIS): targets youth who are at risk of imminent placement with DJJ; instead, the court orders participation in UDIS, which helps the youth develop healthy lifestyles.

Critical Issues and Trends: According to DJJ, it costs on average $85,000 per year to commit a child to its detention programs. It has been demonstrated that community-based programs are generally a less expensive intervention. The most cost-efficient and effective way to serve youth who are at-risk is to reach them early and prevent further involvement in the justice system. A continued focus on prevention and early intervention services, along with effective aftercare services, will help decrease the population of youth who must be housed in institutions and will lead to better social and societal outcomes. As youth are diverted, facilities can be reorganized and staffed to provide quality human services to the population in greatest need of intensive services.

Domestic Abuse, Sexual Assault and Elder Abuse and Neglect Programs

Overview: Since June 2009, the Illinois Coalition Against Domestic Violence has documented more than 70 homicides due to domestic violence in Illinois. Domestic violence, sexual assault and elder abuse programs provide a network of safety, legal and clinical counseling, and other services to victims of abuse and their families. Another purpose is to provide teaching and counseling aimed at educating the public about these public health concerns and the services available to intervene as well as preventing these kinds of violence and abuse. This is also the focus of the Healthy Families program, a child abuse prevention program included in this subsection.

Government funding for these programs is relatively recent, having begun around 1980 in response to growing awareness in society of the pervasive nature of these problems and the appropriateness of a role for government and the law. GRF dollars peaked about 2000 and has gradually gone down in the past ten years. Under the current federal administration, there is movement to increase Violence Against Women Act (VAWA) and Victim of Crime Act (VOCA) funding, but these funds are often dedicated to specific services.[2] For this reason, GRF and other private / philanthropic support secured by community providers provide are relied upon as well.

Funding for emergency, longer-term and prevention services in all areas has never gained on the need, which sets up a tension between these equally vital services. Meanwhile, it is thought that the

[2] It should be noted that through the efforts of DHS-DMH, Singer Mental Health Center in Rockford was selected as a pilot site in a US Department of Justice, Office of Violence Against Women study entitled “Accessing Safety & Recovery Initiative“ (ASRI).

increasing constraints on many community-based service over the past ten years (e.g., community mental health services, programs for the homeless, substance abuse treatment) has produced an increase in the incidence of violence and abuse that coincides with a reduction in the ancillary services needed to deal with it.

The main current trend is that the stresses of the recession similarly are thought to increase the incidence of violence. There are also unique manifestations of the violence and the reaction by the victims within various and growing immigrant communities. These manifestations require targeted programming and knowledgeable practitioners. While these other environmental realities may be stressors which contribute to increased intimate partner violence, the choice to abuse remains, of course, with the abuser who must always be held accountable for this behavior.

Populations Served - Domestic Violence: The population that receives domestic violence services is mostly female adults with children, and between the ages of 20 and 39 years. In FY 09, 33 percent of adult clients were not employed, while 45 percent were employed full time. Of the total individual adults and children served in FY 09, the largest amount, 55 percent, were white. The second largest population served, 26 percent, were African American. While many are employed, most are low income or do not have immediate access to family income, although there is no means test for the services. The only eligibility requirement is that they self-identify. It was reported that in FY 09, 59,566 individual adults and children received help through the 64 state and federally-funded programs. These programs responded to over 203,589 hotline calls and provided 627,005 hours of services. Residential programs provided 245,165 days of shelter.

The target population for prevention services around domestic violence is also diverse. In FY 09, domestic violence programs provided 111,835 hours of domestic violence prevention and education services that reached 543,953 community members. These programs provide outreach services to victims in court and hospital settings, participate in public education presentations to students, and engage professionals in the criminal justice system such as judges, law enforcement officers, state attorney's staff, court personnel, as well as the general public in addressing the problem of domestic violence. Most programs develop and implement public awareness campaigns such as those used during Domestic Violence Awareness Month in October or other awareness events. Prevention activities are a routine part of most service providers programs. These agencies frequently take the lead in ongoing outreach and collaboration through their local community violence prevention task force. Prevention / education programs in schools throughout the state also reach children, youth and adults from pre-kindergarten classes through college level courses.

Healthy Families is a child abuse prevention program that focuses on first-time mothers and their families. Most of the mothers are young and low-income, referred to the programs from local WIC sites and community health clinics. One requirement is that the programs engage the families within two weeks of the newborn's birth. Another eligibility criterion is a history of domestic violence. "Creative outreach strategies" are used to reach new families. Young mothers and their families receive intensive home visiting services that focus on establishing the bond between child and mother; essential for preventing child abuse. Families are encouraged to stay in the program until the child turns five years old.

The state's Partner Abuse Intervention Programs (PAIPs) direct services toward the perpetrators of intimate partner violence; however, the highest priority of each program is to ensure the safety and rights of victims and their children while preventing domestic violence through effective intervention

strategies and integration with other systems. Over the past three fiscal years, PAIPs reached over 32,000 abusers and provided more than 575,000 hours of service.

Populations Served - Sexual Assault: The populations that receive crisis services, advocacy and counseling services are children, youth and adults who have suffered a sexual assault. This may have been recent or abuse that occurred months or years ago. They may have experienced a single episode or many assaults over a long period of time. In either case, crisis services, advocacy and counseling are critical to aid victims in recovery from the assault. These services enable victims to remain in school, continue employment, avoid developing serious physical and mental health complications and remain productive.

Services can also help preserve families and ensure children stay with non-offending parents rather than entering the child protective services system. The only eligibility requirement for sexual assault services is that a client identifies as a survivor of some form of sexual assault, sexual abuse, sexual harassment, stalking, teen dating violence or prostitution and / or trafficking.

Eighty-nine percent of sexual assault victims who use these services are female; 42 percent are under age 18. Another five percent are over age 50. Nineteen percent are African American and 15 percent are Latino. Illinois Coalition Against Sexual Assault (ICASA) local grantees provided ongoing, in-person advocacy and counseling services to 9,999 victims and significant others in FY 09. These centers had an additional 8,442 crisis contacts with sexual assault survivors.

Sexual assault prevention services (funded primarily through federal funds received through IDPH)[3] allow ICASA funded program staff to reach children from pre-school through college age, as well as adults in a variety of settings: PTA, faith communities, civic organizations, etc. ICASA grantees conducted prevention programs with 484,174 individuals and professional training with 16,113 professional in other agencies who work with sexual assault victims, e.g., police, medical personnel and teachers. Centers are also experiencing increased service requests from women who have been victimized in prostitution, trafficking and commercial sexual exploitation. Added to the current population of victims, these services stretch the thin resources for sexual assault centers to crisis levels.

Populations Served - Elder Abuse and Neglect: The populations that receive case investigation, crisis, legal and advocacy and counseling are adults older than 60. There are no income limits for DOA's program, but the individual must be living in the community, not in a nursing home or other institution regulated by the state, and there must be an identified perpetrator.

In some cases, elder abuse and neglect is domestic violence grown old. In other situations, it is primarily about mismanagement of financial resources, often by the caregiver who may be a child, grandchild or paid helper. DOA's program reaches over 11,000 individuals a year and finds ways to reduce tension, stop abuse and avoid recurrence.

[3] DHFS notes that it administers the State Sexual Assault Survivors Emergency Treatment Program, which pays emergency outpatient medical expenses and 90 days of related follow-up care for survivors of sexual assault. DHFS has an on-line registry for hospitals to register sexual assault survivors for the program. This registry, completed during the initial emergency room visit, produces a voucher that allows the assault survivor to obtain follow-up care from community providers. The benefits provided under this program are financed entirely with state funds. In fiscal year 2009, approximately $1.9 million was paid for medical service provided to 1,012 sexual assault survivors.

All three programs – domestic violence, sexual assault, and elder abuse and neglect – reach new populations of victims each year. For example, a three-year federally-funded project focusing on sexual assault with DHS to enhance services to women with disabilities is being implemented statewide in FY 10 – 11. This will result in more women with disabilities reporting to sexual assault crisis centers for services, more demands for prevention programs for women with disabilities and professional training for staff in disability service agencies. A similar three-year federally-funded project is being conducted with the Domestic Violence and Mental Health Policy Initiative to determine how battered women with mental illness access services through mental health agencies and domestic violence agencies. A new but as yet unfunded program to reach out to elders who are described as "self-neglecting" is waiting to be implemented.

Service Delivery System: Almost all of the state funds originate with DHS's division of Community Health and Prevention or, in the case of elder abuse, with DOA. Almost all of the services are provided by community non-profit agencies.

Service Delivery System - Domestic Violence: Domestic violence services are provided by in all 102 counties via 64 community agencies, 38 of which are residential. These are nonprofit agencies that either provide domestic violence services exclusively or are part of a multi-program agency with a domestic violence component. Each agency must provide safe, confidential services in a facility that meets all state and local health and safety requirements. Direct service staff must complete 40 hours of training in accordance with the Illinois Domestic Violence Act (IDVA).

Services provided to victims and their children include crisis response, emergency shelter, counseling, advocacy, court advocacy, information, referral, emergency medical care, food, clothing and transportation. Services are delivered in shelters, and also in social service agencies, courthouses and law offices.

A typical service plan for a victim includes: discussion and information sharing around the dynamics of domestic violence, how violence affects children, the client's legal rights under the IDVA; an assessment of the client's situation and future options for living violence-free, including identifying other social services needed by the client and/or family, addressing transportation needs and helping the client to access those services; peer group counseling for emotional support. Children are also provided age-appropriate services. Service plans emphasize providing the emergency shelter and intervention necessary to save lives and avoid lethal situations.

These primary, proven services require the bulk of the system's resources. When victims present co-occurring problems (e.g., mental health, substance abuse) or need transitional housing or job training (which may not be available in all communities), this further challenges the delivery network.

For Healthy Families, funding goes from DHS to local agencies, both community nonprofits and government health departments. In 2007, a statewide network of 50 Healthy Families programs served more than 4,300 families. While it is a statewide program, it is not an entitlement program and so there are many parts of the state without access to it.

PAIPs provide domestic violence perpetrator services such as assessment, individual and group education and / or counseling and case coordination with referral sources. Other supplemental services can include information and referral, and systems advocacy. These services help perpetrators accept responsibility, modify abusive attitudes and beliefs and give them tools to become and remain, healthy,

non-abusive partners and parents.[4] These programs also provide primary prevention services such as anti-violence programs in schools, public awareness campaigns, community education and collaboration.

Currently there are 72 IDHS protocol-approved PAIPs in Illinois including one in every judicial circuit. PAIPs are delivered through victim service providers, mental health and substance abuse treatment agencies and other community-based social service agencies. The state protocols require all PAIPs to serve indigent and low-income individuals.

It should also be noted that DHS provides the Illinois Domestic Violence Help Line, 1-877- TO END DV, a toll-free, 24-hour, 7-days-a-week, multilingual, confidential service to all Illinois residents that provides access and direct referral to all domestic violence service provider agencies via three-way phone linkage. The Help Line increases access to services for many victim populations, including those in smaller communities who may be reluctant to contact their hometown provider, and immigrant victims who do not speak English. The helpline addresses the need of many domestic violence service providers to provide multi-lingual services. It links victims to interpretation services in more than 170 languages and has capability to serve the deaf and hard of hearing.

Finally, it should be noted that the IDVA's confidentiality provisions are recognized as being the most stringent in the country and limits the sharing of client information.

Service Delivery System - Sexual Assault: In the 1970s, rape crisis services evolved directly from the victims who had been assaulted and found no viable service focused on their experience of sexual trauma. The focus, at the start of the services and to this date, has been on victim-centered services geared toward trauma recovery and victim choice/empowerment. ICASA emerged as a network of volunteer, community-based, non-profit agencies bonded in the common purpose of aiding victims and providing community-wide prevention education. Service standards and training for workers evolved to ensure accountability and to guarantee consistent quality of services. State and federal funding enabled the expansion of specialized services to children in the late 1980s.

Today, ICASA allocates state and federal funds, and monitors the contracts in accordance with their service standards specific to best practices and evidence-based service models for victim services and prevention. Sexual assault services provided by sexual assault center grantees are as follows: 24-hour crisis hotline; 24-hour medical advocacy; advocacy throughout the criminal justice process; in-person counseling (individual, family, group); information and referral for victims and the community; institutional advocacy to promote improved responses by medical and criminal justice systems, schools, social service systems and others; awareness and prevention education; and professional training (for physicians, nurses, police, state's attorneys, educators, social service workers, public health workers, etc.). The direct services to victims are focused on trauma recovery. The education and community services are focused on prevention of sexual violence and improving community responses to victims.

Sexual assault services are provided by non-profit sexual assault crisis and prevention centers through 33 primary offices and their satellites. The services reach 89 counties and are accessible to 98 percent of

[4]It should be noted that abuser services provide a service to the criminal justice system as well as the child welfare system. The enactment of the Cindy Bischof law in January 2009 thrust DHS protocol-approved partner abuse intervention programs into the role of conducting risk assessments for the courts. PAIPs across the state worked closely with law enforcement, the judicial system and victim services to respond to concerns about victim safety and offender accountability.

the state's population. The satellite and outreach offices are situated to reach particular underserved geographic areas and populations. Close collaboration with schools and other community partners are an essential part of the work.

Elder abuse and neglect: Funding flows from DOA to local Area Agencies on Aging (AAA) to local elder abuse programs, most but not all of which are situated in an agency that also provides the Community Care program for seniors. Family dynamics, including the traditional role of the older persons within the family require a careful balance of law enforcement and domestic intervention. This is a program that must be available to all seniors regardless of where they live in the state. So, all 102 counties have a designated provider of Elder Abuse services. Close collaboration with the law enforcement personnel, the courts, and providers of senior services is critical.

Funding: All of these programs are funded through grants or non-Medicaid based fee-for-service contracts. This means that the programs in this category took significant cuts in FY 10 compared to FY 09. This was not a policy choice, for the most part, but a reflection of the fact that almost all of the cuts forced by the budget resolution in August 2009 were made to "contracted services" not protected by the Medicaid freeze in the federal stimulus. Literally all of the programming in this category is done by contract and without fee-for-service Medicaid matching funds.

Domestic Violence: Emergency services in this category comprise the bulk of funded services and are delivered pursuant to contracts, with broad numerical deliverables.[5] That is, emergency services are delivered as needed and not limited based on individual case histories or prior encounters. Thus, there has been almost no "Medicaidizing" of this field, which would require individual eligibility screening and fee-for-service billing.

Funding for domestic violence programs come from the General Revenue Fund (GRF), Domestic Violence Shelter and Service Fund (DVSSF), Donated Funds Initiative (DFI), and Family Violence Prevention and Services Act (FVPSA). The amount of the Domestic Violence Shelter and Service Fund varies annually as it depends upon how many fines each Illinois County's circuit clerk collects from perpetrators of domestic battery and various other crimes against family and household members and the number of commemorative birth certificates sold. The Donated Funds Initiative is an annual block grant award to the state from the U.S. Department of Health and Human Services (DHHS). The Department of Health and Human Services also awards the federal Family Violence monies to the State. This award is a formula-based grant awarded to states based on population and is the only federal fund dedicated to support domestic violence shelter and related services. In FY 10 Illinois, being the 5th largest state, received approximately $3 million.

Additionally, DHS requires programs to match the agency's award with a percentage of private or other governmental monies. In FY 09, the match requirement was 17 percent of the IDHS award.
Federal support also comes from VAWA and VOCA funds. After a period of stagnation, the Obama Administration budget proposals are encouraging; however, right now, over 75 percent of the funding for core programs as provided through DHS is from state GRF. Most prevention and public education programs are funded with federal or special funding, such as foundation grants or school funds. These

[5] Since July 2008, all DHS-funded domestic violence programs are contractually required to collect response to outcome measure questions from service recipients. The responses are reported on a quarterly basis in the InfoNet Data system for submission to the Federal Family Violence Shelter and Services Act Annual Report.

programs are drying up as all sources of funding are needed to address state budget cuts and late payments for the core services.

DHS funds 26 of the state's 72 PAIPs. Funding for these programs began in FY 00 as funds were carved out from the domestic violence GRF (at about $1 million). GRF dollars have decreased since the inception of the program and is currently under $800,000 to support the statewide network.

Sexual Assault: The local agencies rely almost exclusively on GRF for management and infrastructure. These dollars keep the doors open, pay the bill for 24-hour hotlines and pay the executive director's salary, since all federal funds for sexual assault services are restricted to direct service costs (e.g., counselors, advocates, prevention workers). The funding crisis has diminished local grantees' capacity to raise funds in the community and federal funding has been reduced or stagnant. Though the 24-hour crisis, advocacy and counseling services are key deliverables, they cannot be provided without management support, adequate office space and other support such as utilities and phones.

Elder Abuse: This is a "fee for service" program. Even as requests for help increase, state funding is decreasing because it is not connected to Medicaid dollars. Funding decreased from $10,041,400 to $9,937,000 for FY 10.

Critical Issues and Trends: There is growing evidence of the impact of domestic and sexual violence on children and young adult survivors and the impact of the violence on their ability to stay in school, stay safe while in school and successfully complete their education. Increased interventions are needed to help these survivors. Local agencies frequently report that lack of access to transitional housing and / or job training often cause a victim to return to her abuser. There has been in the past limited federal funding through the Illinois Criminal Justice Information Authority (ICJIA) to support specialized services for children who witness domestic violence, but these services were reduced in FY 08.

As noted above, home visiting is a critical part of the Healthy Families program. In the new health care reform legislation, there are significant new dollars for home visiting, which offers the promise of expanding this program, depending on state maintenance of effort.

Regarding sexual assault programs, services are key to the recovery of victims. Sexual assault is a serious form of violence and a violation of human rights. It is also expensive, with cost per victim estimated at $127,000.[6] Many of these costs are passed on to government agencies in the form of unemployment, health care, mental health services, police and criminal justice system costs, corrections costs, etc. Prompt crisis response and trauma-focused services aid victim recovery and ameliorate the development of the costly, long-term, negative outcomes of trauma such as psychological illness, substance abuse, school failure, loss of employment and suicide.

Finally, regarding elder abuse and neglect, as the population ages and becomes frail but remains in the community, incidences of elder abuse are expected to increase. There is also a problem and question of how intervene most effectively with elder abuse self-neglect cases. These cases are much more time-consuming for elder abuse social workers; however, payment is based on cases closed; not on time needed to help the client.

[6] Mark A. Cohen, "Measuring the Costs and Benefits of Crime and Justice," *Criminal Justice 2000, Vol. IV: Measurements and Analysis of Crime and Justice.* (Washington, DC: National Institute of Justice, July 2000), page 30. Available at: http://www.ncjrs.gov/criminal_justice2000/vol_4/04f.pdf.

SENIOR SERVICES

Overview: Two thirds of all the older persons ever to live on earth are alive today, a phenomenon mostly due to public health advancements. In response to this, state and federal governments have established a range of programs and policies that include Social Security, Medicare, Medicaid, senior housing and transportation, the Older Americans Act (OAA) and AmeriCorps. These services for older persons reflect our society's willingness to answer their needs today and tomorrow.

The OAA and Illinois Act on Aging provide resources to implement service plans developed by AAAs with the advice of community members and utilizing community organizations. The total provided for this "aging network" from federal and state funds total just over $61.8 million (including programs outside the scope of this report), with additional resources directed to the aging network under Senior Health and Assistance Program, Elder Abuse and Neglect Program (discussed above) and other state programs to help older persons find the information they need on community programs and identify benefits, services and supports to continue to live safely and independently.

Aging has clear biological effect on many senses and functions as we age. As individuals grow older, their risk of dementia increases. As their ability to function and interact with others diminishes, their support system can shrink as well. The OAA offers tools for communities to respond to the aging of their residents. AAAs oversee a number of evidence-based service programs that address major issues for older persons: information and support in decision making; transportation; home care; legal assistance; family care giving; respite services; grandparents raising grandchildren; understanding pharmaceutical and other benefits in health care plans; barriers to obtaining benefits from federal, local and state governments; limited-English speaking and minority elders; rural areas; low-income and poverty subsistence; social and recreation activities to sustain health and vigor; socialization and volunteer opportunities; and senior center services.

Populations served: The Illinois aging network has supported communities for over 35 years and touched in some capacity one quarter of all older persons in Illinois in 2009. DOA reports that over 500,000 people were reached with services and programs in FY 09. This figure is more accurate than previous years (where the numbers were actually lower) due to improved information systems.[7]

People who seek services are doing so at a younger age, as economic hardship from mortgage foreclosures, securities fraud and mental illness have caused more to seek assistance. The clientele is predominantly female, over the age of 75, widowed, lower income, isolated with absent or distant family support, confused by information coming from health insurance and the government and limited in mobility and functioning. The assistance they need is more complex and layered than in the past, since legal issues are more common, as are financial crimes, scams and frauds.

Service Delivery System: Most services are offered in person or by telephone to seniors. There are group programs in community centers as well as in-home supports and counseling in service offices.

[7] We know that Illinois has a network that reaches every part of the state with key support that builds our capacity to serve older persons; however, more work needs to be done as currently little information is collected about physical conditions, family status, frequency of services, and outcomes from the aging program system.

Community Based Services are delivered by community based organizations selected through regular request for proposal processes by AAAs. Services are identified by a regional Area Plan on Aging, as prepared by the AAAs every three to four years. AAAs monitor programs for compliance to standards set by DOA, with a focus on sharing best practices.

There are regional and local differences in service provision. With state and federal funds providing seed funds, AAAs obtain local resources to complete their programs. Monitoring assures compliance to basic standards, but not always consistency and uniformity across the region or state.

Multiple organizations and a layered service system design can produce issues around communications and authority. There are also issues around obtaining information in all areas of the state to ensure that the aging network reaches those in greatest need. The current information systems do not offer a depth of knowledge about clients and their needs and the capacity of AAAs across the state varies.

Several major senior centers are transitioning into social service centers. New models for delivering services are being tested and utilized by community agencies, e.g., the BenefitsCheckUp.org was developed by the National Council on Aging from work performed in Illinois. The Enhanced Services Program (ESP) is a web resource database of aging and long-term care services that was rolled out in parts of the state two years ago. AAAs have moved to bring ESP statewide, but this is not yet done.

The implementation of statewide standards for information sharing therefore remains in need of attention. Legislation passed five years ago to increase the capacity of the aging network resulted in a check list of activities to advance the network and the Older Adult Services Act continues today to offer guidance and vision to transform aging services, through improved local information access, staff knowledge, tools and resources.

Funding: Dollars that leverage federal funds were sustained in the FY 10 budget. The Community-Based Senior A line item that evenly distributed $1.9 million to the thirteen local AAAs was reduced as part of across-the-board reductions, while population-based funding was sustained.

Critical Issues and Trends: One important trend that concerns funding is that communities are scaling back senior service programs, as villages, townships and metropolitan organizations adjust budgets under a poor economy. Most funding for OAA programs is directed to a community network that is the infrastructure of all programs for older persons. Sustaining the overall health of that larger infrastructure is therefore the challenge of these times, so that future generations of seniors will not be left with only a senior-focused market of scammers and defrauders.

Secondly, excessive delays in payment from the state resulted in accelerated use of federal funding, reductions in staffing, furloughs and slower and less complete responses to requests for services. Local agencies are exhausting reserves and taking out lines of credit, with the total burden of paying interest costs left to the agencies.

The Illinois aging network is similar to service programs in all 57 states, territories and Native American tribes. Where Illinois has increased reliance on Medicaid supported programs, other states have done the same with the building blocks from the aging network. Today, DOA administers funding for case management (Comprehensive Care Coordination) and AAAs are working with the department to establish aging and disability resource centers throughout Illinois.

There is no new funding for these centers, only the opportunity to use existing resources to improve the information available to older persons and their families, especially in situations where long-term care services and supports are required. This includes much-needed consumer protection and advocacy for older persons that can be put on web sites and incorporated into staff training of all Illinois Information and Assistance staff. Rarely is a system so well positioned as the locally based aging network to reduce state costs and liabilities. We have the information, the coalition and the support of federal and state leaders to assure that independence, dignity and respect for elders are operationalized in the community.

The goals of the state's Older Adult Services Act represent a clear direction for increasing the effectiveness of home and community based services and reducing reliance on long-term care facility services. To some extent these changes occur because of the economic situation, customer preferences and health improvements, but many states use their informal support systems and service programs as a base for moving oversight and authority closer to the community.

Refugee and Immigrant Services

Overview: The Bureau of Refugee and Immigrant Services within IDHS funds, manages and monitors contracts with non-profit providers designed to help newly arriving refugees achieve self-sufficiency in the United States through access to health care, education and citizenship services, and outreach and interpretation to limited English proficient individuals requiring supportive services.

Populations served: Based on the 2000 Census, 1.5 million immigrants, 60 percent non-citizens, resided in Illinois communities. Since l975 Illinois has resettled more than 115,000 refugees from more than 30 countries. Over 88,000 individuals are served through the IDHS Bureau of Refugee and Immigrant Services programs each year. Services for these programs are available for newly arriving refugees, low-income immigrants, resident non-citizens, and limited English proficient individuals.[8]

Service Delivery System: Illinois also funds specialized refugee mental health services to address treatment needs that are not addressed by federally funded programs. Immigrant and refugee services are delivered through community-based programs across Illinois. Health care is provided through grants to four suburban clinics with substantial immigrant client bases reaching approximately 9,000 clients. Translation and interpretation services in a broad range of languages are administered through 35 agencies and administered by non-profits. English as a Second Language, civics, and citizenship application services are administered to more than 100,000 immigrants throughout Illinois via dozens of non-profit agencies. The Refugee Program provides community-based adjustment counseling, orientation, English as a Second Language, vocational training, job readiness, and job placement through various program sites; six in Chicago and four outside Chicago city limits.

Funding: According to FY 10 budget data provided by DHS, Refugee and Immigrant Services funding totaled $11.8 million.

Critical Issues and Trends: Need for refugee services depends on global issues, requiring a level of responsiveness that is tailored to the needs of diverse resettling populations. With comprehensive immigration reform on the agenda in DC, changes to the immigration system and potential new

[8] Illinois Department of Human Services, available at http://www.dhs.state.il.us/page.aspx?item=30363

opportunities for immigrants to pursue citizenship also point to the need for a new infrastructure of community based legal service, one that is able to effectively and responsibly provide legal guidance to individuals.

Human Service Category: Individual and Family Support

Data Source: State agencies as indicated in the first column

Youth Development and After School Programs

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DHS-CHP	Teen REACH	The purpose of the program is to expand the range of choices and opportunities that enable, empower and encourage youth to achieve positive growth and development, improve expectations and capabilities for future success; and avoid and/or reduce risk-taking behavior.	Positive Youth Development	$15,994,900
ISBE	After School Matters	To align key public partnerships with the City of Chicago, the Chicago Public Schools, the Chicago Park District, the Chicago Department of Children and Youth Services, the Chicago Department of Cultural Affairs and the Chicago Public Library with the resources of private and non-profit organizations to offer compelling, after-school programs to Chicago teens.	To offer more than 25,000 after-school and summer opportunities to teens through 1,032 programs taking place at 57 campuses anchored by Chicago Public high schools and 166 community based organizations throughout the city of Chicago.	$5,000,000
DHS-CHP	Gear Up Illinois Steps Ahead		Positive Youth Development	$1,029,600
DHS-CHP	Mentoring Children of Prisoners		Positive Youth Development	$148,200

Youth Delinquency / Violence Prevention Programs

DHS-CHP	Comprehensive Community Based Youth Services	The primary purpose of CCBYS is to provide youth in high risk situations, and their families when appropriate, with a continuum of services according to their needs, with the overreaching goal of family preservation, reunification and/or family stabilization, or independence, again dependent upon the youth's needs.	Family Reunification	$9,897,000
DHS-CHP	Community Youth Services	To reduce and prevent juvenile delinquency	Positive Youth Development	$5,771,810

DHS-CHP	Communities For Youth	The CFY program was created in response to Illinois' Juvenile Justice Reform Act of 1998, which seeks to protect citizens from juvenile crime, to hold each juvenile offender accountable for his or her acts, and to provide an individualized assessment of each delinquent juvenile.	Positive Youth Development	$2,784,200
DHS-CHP	Unified Delinquency Intervention Services	The purpose of the program is to divert youth from further involvement in the criminal justice system.	Family Reunification	$2,707,300
DHS-CHP	Redeploy Illinois	Redeploy Illinois provides a fiscal incentive to counties that provide services to youth within their home communities by building a continuum of care for youth who are in the juvenile justice system, thereby reducing the county's commitments to the Illinois Department of Juvenile Justice. Research demonstrates that non-violent youth are less likely to become further involved in delinquent or criminal behavior if they remain in their home communities and if appropriate services are available that address underlying needs – e.g., mental illness, substance abuse, learning disabilities, unstable living arrangement.	Balanced and Restorative Justice	$2,593,200
DHS-CHP	Delinquency Prevention	The purpose of the Delinquency Prevention program is to divert youth who have committed a delinquent offense from deeper involvement in the juvenile justice system.	Positive Youth Development	$1,082,300
DHS-CHP	Safety Net	Direct service response initiative that encompasses a preventive and rehabilitative approach to addressing youth violence in Illinois.	Violence Prevention	$410,000
DHS-CHP	Release Upon Request	The purpose of the RUR program is to ensure that youth are removed from detention within 24 hours of referral. Once that is accomplished, the focus of the program turns to efforts to reunify the family.	Family Reunification	$280,800

DHS-CHP	Truancy Review Boards	These boards utilize community based youth services with a goal of decreasing truancy in youth and increasing school attendance. In some grantee locations, improvement of grades is another goal. It is a requirement for all grantees to comply with the federal Juvenile Justice Delinquency Prevention Act (JJDPA), ensuring elimination of the practice of detaining truant youth.	Balanced and Restorative Justice	$55,500

Child Welfare

DCFS	FOSTER HOMES AND SPECIALIZED FOSTER CARE	Provides primary funding source for all foster care board payments and insures sufficient funds for reimbursement of foster parents; provides funding for private agencies to ensure maintenance of appropriate caseload ratios	Ensure child's safety; provide quality care to meet developmental, educational, and social needs; achieve permanency in a timely manner	$304,072,000
DCFS	INSTITUTION GROUP HOME CARE AND PREVENTION	Funds for the care and provision of DCFS wards in child care institutions who are experiencing serious physical, emotional, behavioral or mental health related problems	Provide a stable treatment setting; with quality programming; and improved placement stability in less restrictive settings	$256,039,600
DCFS	PURCHASED CARE OF ADOPTION SERVICES	Provides funding for adoption subsidies and for post-adoption services, including legal services to adoptive parents, therapeutic day care and other services provided to adoptive parents	To create, and maintain a healthy, permanent home for children who have experienced severe abuse and/or neglect	$248,011,400
DCFS	PROTECTIVE/FAMILY MAINT DAY CARE	Funds all day care for both employment related for foster parents as well as protective day care for intact services	Provide safe and healthy day care to protect children from abuse	$25,928,500
DCFS	COUNSELING SERVICES	Covers all counseling services for wards and families and auxiliary services, such as intact services, respite services, mentoring services and after school services	Correct abuse patterns in families; and help children overcome trauma	$24,175,700
DCFS	FAMILY PRESERVATION PROGRAM	Funds all intact family services	Safely maintain children with their parents; minimizing trauma and preventing expensive substitute care costs	$18,047,400
DCFS	FAMILY CENTERED SERVICES	Funds four primary areas which include intact services, adoption preservation, Extended Family	Provides essential services in compliance with Title IV-B, Part	$16,489,700

	INITIATIVE	Support Services and LANS	II funding requirements	
DCFS	FOSTER CARE AND ADOPTION CARE TRAINING	Funds all training to all foster parents and all DCFS and private agency staff	Train foster parents and staff; maximize federal reimbursement opportunities	$14,608,500
DCFS	INDEPENDENT LIVING INITIATIVE	Provides funding for independent living programs	Provides services to assist youth in care to successfully transition to adulthood	$10,300,000
DCFS	TARGETED CASE MANAGEMENT OPER AND COMM	Provides funding for child welfare caseloads and for special cases	Maintain safe caseload ratios and support for placement cases	$9,307,700
DCFS	SERVICES ASSOC WITH FOSTER CARE INITIATIVE	Funds supportive foster parents including payment for respite care, training for foster parents and transportation for foster parents. Funds also used for assisting relatives to pursue licensing.	Supports foster parents for improved placement stability; and licensure activities which increases federal claiming	$8,289,300
DCFS	CLASS DEFINED IN THE NORMAN CONSENT ORDER	Provides services for families in need for Norman Services and housing locater services as required by Norman Consent Decree	Emergency assistance to prevent children from entering placement or to reunify more quickly	$3,503,300
DCFS	CHILDREN'S ADVOCACY CENTER	Provides funding for Children's Advocacy Centers statewide and these centers provide assistance with child abuse and neglect investigation and provide services to children and families	Child-sensitive interviews assist in prosecutions; and coordinate treatment for sexually & physically abused children	$3,467,700
DCFS	PSYCHOLOGICAL ASSESSMENTS	Provides for psychological assessment for all DCFS wards and their families, provides assessments intact families and also provides for assessments that can be used during child abuse and neglect investigations	Improved documentation for court cases; and assistance in treatment planning	$3,273,600
DCFS	PRE ADMISSION/POST DISCHARGE PSYCH SCREENING	Funds all services relating to SASS services for DCFS wards	Assessment for psychiatric hospitalizations; and provide discharge planning	$3,200,200
DCFS	CHILDREN'S PERSONAL AND PHYSICAL MAINTENANCE	Funds services for all DCFS wards, including such things a clothing vouchers for when a ward comes into care, all services not covered by Medicaid, such as chairlifts or other equipment needed for disabled or special needs	Ensure children in state custody receive proper care and services	$2,856,100

DCFS	PURCHASE OF CHILDREN'S SERVICES	Funds adoption preservation services and other services necessary to prevent adoption disruptions and also preventing children from re-entering into care	Stable post-adoption placements	$1,314,600
DCFS	YOUTH IN TRANSITION PROGRAM	Covers services for all children in foster care that are transitioning to independent living including Youth in College (YIC) program	Help youth successfully transition out of state care	$966,400
DCFS	CHILD ABUSE PREVENTION	Tax check off funds from state taxes which funds putative father registry	Maintains the state's putative father registry	$600,000
DCFS	PRIVATE FUNDS FOR CHILD WELFARE IMPROVEMENT	Funding directly from federal government for specific projects related to various issues supporting of a child's well being	Provides appropriation authority for grant awards	$344,000
DCFS	REIMBURSING COUNTIES	Provides funding for non DCFS ward cases for diversionary programs for juvenile justice programs pursuant to 705 ILCS 405-5-515	Reimburse counties for a portion of their diversionary placement expenses	$338,500
DCFS	COOK COUNTY REFERRAL SUPPORT SYSTEM	Funds secondary placement network for DCFS and agencies in Cook County when they need to an alternative placement of a minor; also used to cover residential care	Ensures that children in care are placed quickly; in the most appropriate setting; as close to home as possible	$247,200

Early Childhood Education, Development and Parenting

DHS-HCD	Child Care	To provide families of low income with access to affordable, quality child care options that allow them to pursue self-sufficiency and contribute to the healthy development of children, and to enhance the quality, affordability, and supply of child care.	Increased economic independence and productivity for families; Accessible and affordable child care services; Improved quality of care.	$777,011,600
ISBE	Early Childhood Education	Programs funded by this initiative include the pre-kindergarten program for children at risk of academic failure (screening and educational programs for at-risk three and four year olds), the Early Childhood Parental Training Program (training in parenting skills for prospective parents and parents of very young children), the Prevention Initiative (a network of child and family service providers that promote the development of at-risk infants and children), and the Preschool for All Children Program (screening and educational programs for three and four year olds) based on the following priorities: 1) children who have been identified as being at risk of academic failure, 2) children whose family's income is less than four times the poverty guidelines, and 3) other.	To allow Illinois students to enter school with a foundation of knowledge and skills that allow them to be successful throughout their school experience.	$342,235,300
DHS-CHP	Early Intervention	To support families in promoting their child's optimal development and to facilitate the child's participation in family and community activities.	Early Childhood Development	$144,200,000
DHS-HCD	Child Care ARRA			$73,772,628

DHS-CHP	Parents Too Soon	To provide support and assistance to teens who became parents and develop: -Healthy parent-child relationships; -Healthy growth and development of children of pregnant and parenting teens; -Reductions in rates of subsequent births; -Improved health and emotional development of pregnant and parenting teens.	Healthy parent-child relationships.	$8,836,900
DHS-CHP	Teen Parent Services	To increase below-post-secondary school completion, reduce subsequent pregnancy, improve parenting skills, increase the rate of the immunizations, well baby visits, and screening for developmental delay for children of teen parents.	Teen Pregnancy Prevention	$4,968,500
DHS-HCD	Migrant Head Start	Migrant and Seasonal Head Start provides seasonal, full-day child care and comprehensive support services to farm-workers.	Developmentally and culturally appropriate early childhood education for children six weeks to six years of age; social services and education for migrant and seasonal parents; medical and dental treatment for Head Start children; inter-generational liter	$3,165,957
DHS-CHP	All Our Kids Networks	To ensure that babies are born healthy, children maintain physical and emotional health, children enter school ready to learn, families are connected to services they need and parents are leaders in their communities.	Early Childhood Development	$1,048,100
DHS-HCD	Crisis Nurseries	Round the clock crisis care of children, home visiting, parenting classes, parent support groups, crisis counseling, referral and linkage to after care services.	Family self sufficiency, prevention of neglect and abuse, improved family functioning, stress reduction, employment.	$424,900

DHS-CHP	Strong Foundations	The goals of Strong Foundations are to build and sustain a vital state infrastructure to support evidence-based home visitation programs (including Healthy Families Illinois, Parents and Teachers, and Nurse-Family Partnerships) for young families to prevent child abuse and neglect; and to provide the resources to support successful home visiting programs in communities.	Early Childhood Development	$405,000
DHS-CHP	Teen Parent Family Centers	By expanding the scope of service delivery to the family members the program aims to reduce subsequent births, increase family employment rates and high school graduation rates or GED attainment as well as future educational aspirations, increase child health through the immunizations, well baby visits and screening for developmental delay, and strengthening parenting skills and positive family interaction.	Teen Pregnancy Prevention	$365,000
DOC	Parenting Classes	To provide parenting skills to female inmates at Dwight CC	To make the female inmates better parents upon release from prison	$26,000

Domestic Violence, Sexual Assault and Elder Abuse and Neglect Programs

DHS-CHP	Domestic Violence Prevention and Intervention	Services are offered to help victims of domestic violence by giving them the tools they need for safety and self-sufficiency, as well as to promote prevention through education and outreach.	Violence Prevention	$22,277,000
DOA	Elder Abuse and Neglect Program	To respond to reports of abuse, neglect and exploitation perpetrated against older adults who reside in the community. The program attempts to build on the existing legal, medical and social service system to assure that it is more responsive to the needs of elder abuse victims and their families.	Receipt of needed services or interventions by elder abuse victims; reduction in the risk of further injury or harm to those who have been victimized; increased reporting of elder abuse; prevention of abuse, neglect or exploitation.	$9,937,800

DHS-CHP	Healthy Families Illinois	Healthy Families Illinois provides information, training and support to assist parents to improve their families' functioning, thereby reducing their risk for child maltreatment. Goals include: -Healthy parent-child relationships; -Healthy growth and development of children of pregnant and parenting teens	Violence Prevention	$8,519,100
DHS-CHP	Sexual Assault Prevention and Response	To reduce the incidence of rape and other forms of sexual assault and ensure that survivors of sexual assault have access to quality emergency medical care, crisis support, medical and legal advocacy and counseling services for themselves, families and friends.	Violence Prevention	$4,736,800
DHS-CHP	Domestic Violence Partner Abuse Intervention	Services are offered to reduce and prevent domestic violence through education to abusers and assistance to the court system.	Violence Prevention	$886,400
DOA	Title VII Prevention of Elder Abuse, Neglect & Exploitation			$500,000
DHS-CHP	Parents Care and Share	Prevention of child abuse and neglect	Early Childhood Development	$100,000

Senior Services

DOA	Title III Social Services	Provides federal funding for transportation, information and assistance, legal assistance and other social services.	Older adults receive eligible public benefits, transportation and other services.	$17,000,000
DOA	National Family Caregiver Support	Provides federal funding for caregiver support services.	Family caregivers receive respite, information and access to public benefits, support group, training and education and other services.	$7,500,000
DOA	Community Based Services	Provides financial support and matching funds to federal Older Americans Act state allocations.	Older adults receive transportation, information and assistance, legal assistance and other community services.	$3,062,300

DOA	Planning/Service Grants to AAA	Provides matching funds for federal Older Americans Act state allocations.	Older adults receive transportation, information and assistance and other community services.	$2,241,700
DOA	Senior Helpline	In addition to local information and assistance sites, the Senior Help Line provides information on programs and services and links persons 60 years of age and older and their caregivers to local services.	Provides information & assistance, answers queries about Circuit Breaker, provides referrals to CCP and answers the dedicated Elder Abuse Hotline.	$1,577,700
DOA	Community Based Services (Equal Dist)	Provides financial support to federal Older Americans Act state allocations.	Older adults receive transportation, information and assistance, legal assistance and other community services.	$958,000
DOA	Foster Grandparent	Provides matching funds for federal grant awards from the Corporation for National and Community Service to 11 providers at 305 volunteer stations.	Offers low-income seniors the opportunity to earn a small stipend while meeting the needs of children and youth.	$307,900
DOA	Grandparents Raising Grandchildren	Establishes support groups and other services for grandparents raising children (GRG), provides training for professionals, and provides information and assistance services to GRG and professionals.	Relatives gain access to services and resources. Supports the federal funding through the Older Americans Act by serving GRG under the age of 55. Federal funding can only be used for GRG age 55 and older.	$302,900
DOA	Intergenerational Programs	Provides grant awards to community-based organizations which promotes opportunities for persons of all ages to collaborate and address critical social problems through partnerships.	Younger people gain a greater understanding of the aging process. Critical social problems are addressed.	$54,800

Other

DHS-HCD	Donated Funds Initiative	Various types of social services to address the needs of seniors, ex offenders, substance abuse, unemployment, family functioning, youth development, developmental disabilities, mental health, and domestic violence.	Employment, recovery from substance abuse, improved family functioning, prevention of isolation, coping skills, community integration, prevention of abuse and neglect, self sufficiency, self support, prevention of institutionalization	$20,603,933

DHS-HCD	Refugee & Immigrant Services	Refugee Integration and immigrant citizenship	Self-sufficiency and assimilation	$11,840,748

Mental Health

Overview

Severe mental illness is a prevalent, expensive and difficult concern for state human services systems. Four of the ten leading causes of disability are mental illnesses and every year, the Social Security Administration spends over $30 billion on disability payments for persons with mental illness.[1] In Illinois, one in 17 residents lives with a serious mental illness.

The term "mental health services" broadly describes a wide range of behavioral health supports and services. These services are provided directly or indirectly by a number of state agencies, often as a small part of the agency's mission (with one exception noted in the list below). This section focuses on mental health services provided by the Illinois state agencies that are responsible for the majority of mental health services and for setting state mental health policy,[2] specifically:

- Illinois Department of Human Services Division of Mental Health (DHS-DMH), which has services for mental health care as its sole mission
- Illinois Department of Healthcare & Family Services (DHFS); specifically its Medicaid & related programs
- Illinois Department of Child & Family Services (DCFS)
- Illinois Department of Corrections (DOC) and Department of Juvenile Justice (DJJ)

As the public's awareness of mental health and wellness grows, coupled with a decline in the stigma associated with seeking mental health treatment, the current service system is challenged to meet the demand for services. At the level of service delivery, resource limitations can create problems as people move between systems (e.g., from prison to community-based services) or experience status changes (e.g., aging out of the child welfare system and into the adult system) or require related services provided by a different agency (e.g., employment services needed by people with psychiatric disabilities). Data and other indications of these challenges are discussed later in this section.

According to data provided by DHS-DMH, DHFS, DCFS and DOC, mental health services under their jurisdiction (including DHS-DMH Medicaid Waiver services) were budgeted at just under $648 million in FY 10. These figures are summarized in the following table and detailed, by program, at the end of this section:

[1] Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15 to 44. Source: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml.

[2] It is important to note that mental health services are provided through other state programs that incorporate funding for mental health services through their benefit structures, even though the mental health benefit is difficult to tease out of the total costs and numbers of recipients. These programs, many of which are discussed elsewhere in this report include child support and TANF (discussed in the Public Assistance section), SNAP (formerly food stamps, discussed under Food and Nutrition) and certain programs under the jurisdiction of DCFS, including those discussed under Individual and Family Support Services. It should also be noted that services for veterans with service-related disorders including post-traumatic stress disorder are not included in this discussion. While ready access to good mental health services specifically designed for veterans is important, meeting this need is primarily a federal responsibility, with services provided through Veteran's Administration health centers.

FY 10 Budget Data for Mental Health

	Total
	$ 647,839,558
Mental Health Services in Corrections System	$ 3,527,500
Mental Health Services for General Population	$ 644,312,058

Resources for mental health services in Illinois are decreasing, a trend that has been underway for at least five years. Many state programs (such as DHS-DMH funded community services) are operating on (inflation adjusted) 2005 levels of revenue.

Populations Served, the Service Delivery System and Funding Details

Since the state agencies deliver mental health services in differing ways, it is necessary to discuss programs by agency. Broadly speaking, mental health services are delivered to inpatients in three settings: state operated facilities, inpatient mental health hospitals, and inpatient units in general hospitals. Licensed long-term care services are provided in two types of nursing homes: Institutions for Mental Diseases (IMDs) and general nursing homes. In addition, there are hundreds of community providers, funded by various state agencies, including those that provide an array of clinical, developmental and rehabilitative services.

DHS'S DIVISION OF MENTAL HEALTH (DMH)

DHS-DMH has primary responsibility for public mental health services in Illinois. In FY 09, DMH-funded providers served 166,187 individuals in community settings and DMH served 8,742 individuals in state mental health centers, with 10,103 admissions to its short-stay inpatient hospitals and 574 court-ordered admissions to its forensic units. The number of individuals served by DMH-funded services dropped by almost 10 percent from FY 08 to FY 09 as a result of funding cuts. In FY 10, DMH has budgeted $229 million for state operated inpatient facilities and $388 million for community services. In addition, the DMH budget includes $28 million for a treatment and detention facility for sexually dangerous persons.

DHS-DMH serves two primary groups directly and through its funded providers. Predominately, DMH serves people designated as part of its "target population." This consists of people with severe, persistent and disabling mental illness. It is DMH's historic priority and is defined as:

> *Individuals with serious mental illness … whose emotional or behavioral functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive*

> *local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services.*[3]

DHS-DMH also serves individuals in the "eligible" population. These are people with less severe levels of mental or emotional disorders that create some milder impairment. It has been observed by consultants to various state Mental Health Authorities that Illinois is unusual for its broad definition of eligibility. Most states focus DMH resources on the target population and allow people with less severe illnesses to be served in non-DMH funded settings or in primary care settings such as Federally Qualified Health Centers.

Similar eligibility takes place for children and adolescents with mental health needs. Youth and their families can more easily access community mental health services through DMH with a target diagnosis, yet many providers will also serve those with eligible diagnoses. Many of these child-based diagnoses become ineligible once a young person ages into the adult mental health system.

There is a growing emphasis on prevention and early intervention of mental illness with children. Since schools and primary physicians tend to be major points of entry for services, Illinois has increased its efforts around educating school personnel and doctors to identify mental health needs and understand referral options. Illinois has placed special emphasis on schools increasing their social-emotional learning for young children, and the developmental needs for youth as they age.[4]

For young people with the most severe mental illness, DMH has the Individual Care Grant (ICG) program, which provided services to 48 children and adolescents during FY 09. Throughout FY 09, 445 children and adolescents used Individual Care Grants. The ICG grant provides community mental health care services or inclusive residential care for youth up to 21 years of age. ICG has increasingly provided in-home services, which are less restrictive than residential services. However, the majority of the youth with an ICG grant continue to be served in-residential settings.

In this context, it is important to note that DMH secured for Illinois two of only twenty multi-year federal grants awarded recently by the Substance Abuse and Mental Health Services Administration (SAMHSA). DMH worked in partnerships with the Egyptian Health Department's PROJECT CONNECT and Champaign County's ACCESS initiatives, respectively to develop the applications in 2009. PROJECT CONNECT will increase the ability of child and youth service agencies in White, Saline and Gallatin Counties to help their clients cope with serious emotional disturbances. PROJECT CONNECT will transform local services into an integrated network of community-based treatment and support services. PROJECT CONNECT will receive $9 million over a six-year period and ACCESS will receive $9 million over five years. DMH will provide technical and clinical expertise and assist in the development and assessment of these projects.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES (DHFS)

DHFS provides mental health services, including inpatient, outpatient, physician, prescription drug and clinic services through its fee-for-service medical program. In addition, DHFS administers several mental

[3]Source: http://www.dhs.state.il.us/page.aspx?item=33556

[4] The Educational Support Services section of this report and Appendix F have for overviews of the Illinois Children's Mental Health Partnership.

health programs and initiatives targeted to specific populations. DHFS provides mental health services through two mechanisms. First, it administers Medicaid services that include mental health services. This includes inpatient, crisis, outpatient, medication, veterans, children's, disease management and other services that include mental health interventions predominately funded for hospital and independent physicians. DHFS also funds nursing homes including specialty mental health homes (IMDs) and conducts a Mental Health Initiative geared at addressing issues regarding the care of individuals with mental illness in nursing facilities. Illinois has relied on these intermediate care options for people with mental illnesses, funding approximately 15,000 individuals in these settings at a cost of approximately $640 million (all of which comes from the General Revenue Fund [GRF]– there is no Medicaid match). DHS-DMH conversely serves 10 times as many individuals in community settings (over 165,000) with half as much funding.

Department of Child and Family Services (DCFS)

Many of the children and adolescents served by DCFS require mental health services. Often these services are integrated with other services being provided by DCFS, making it difficult to separate their cost.

Currently, children who need intensive mental health services are cycling in and out of the hospital and SASS (Screening, Assessment and Support Services)[5] because communities lack sufficient and appropriate intensive in-home supports for these children and their families. This increases costs and the multiple moves and transitions can be traumatic to children who must then go to different hospitals all over the state for intensive services, and consequently are deprived of consistent family contact.

Department of Corrections / Department of Juvenile Justice

About 15 percent of the 46,000 people under the supervision of DOC have a severe mental illness. In addition to the usual costs of incarceration for this large, often minority population, DOC provides specialized mental health services and medication for people while incarcerated. In addition, DOC and DJJ spend $1.8 million on sex offender treatment services and $1.6 million on mental health services for juveniles, respectively.[6]

Critical Issues and Trends

[5] The following definition of SASS comes from DHS's web site: "In an effort to provide improved coordination in the delivery of mental health services to youth, Illinois developed the Screening, Assessment and Support Services (SASS) program for children and adolescents experiencing a mental health crisis. This initiative rolled out on July 1, 2004, as part of the implementation of the Children's Mental Health Act of 2003 (pdf) (html) (Public Act 93-0495), which was signed into law on August 8, 2003. The SASS initiative is a cooperative partnership between the Department of Children and Family Services (DCFS), the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS). The development of the tri-department SASS program created a single, statewide system to serve children experiencing a mental health crisis whose care will require public funding from one of the three agencies. This program features a single point of entry (Crisis and Referral Entry Service, CARES) for all children entering the system and ensures that children receive crisis services in the most appropriate setting."

[6] Here too it should be noted that Illinois spends additional revenue on mental health services through other state agencies. In addition, there are a range of "hidden" costs that result from untreated or inadequately treated mental health illness, including lost productivity, and crisis-driven responses such as police, emergency room and medical services. The Criminal Correctional System section of this report has additional information about DOC and DJJ programs.

A number of critical issues and trends should be considered in any examination of the state's human services system. Since we anticipate that future Human Service Commission reports will address recommendations, the following information is offered to ground these efforts in information about the mental health system's current situation:

- In Illinois, multiple agencies deliver mental health services. Consider the many areas and programs that providers and people must negotiate:
    - DHS-DMH, which manages the core of the system through the Medicaid Community Mental Health Services Program, Rule 132 and some grants.[7]
    - DHFS, which manages Medicaid reimbursement including inpatient services and a network of intermediate care facilities.
    - DHS's Division of Rehabilitation Services, which is responsible for employment assistance to people with disabling mental illnesses.
    - DCFS and the public school system, which functionally absorb most responsibility for providing services to children with severe mental illness.
    - Housing supports for people with severe mental illness, which are scattered across state agencies, including the Illinois Housing Development Authority (IHDA).
    - Mental health services associated with corrections managed by DOC or DJJ.
    - Multiple billing and administrative systems throughout the various state agencies.

This diffuse array of programs makes it difficult to drive design, coordination, funding decisions and performance management and contribute to other system-wide challenges, including the following:

- Data suggest that Illinois under-invests in mental health services: In inflation-adjusted dollars, state spending on mental health has shrunk in each of the past five years. The 2007 final report to the Illinois General Assembly by the Institute of Government and Public Affairs at the University of Illinois noted that our state ranks 35th in per capita spending on mental health services, when adjusted for income.[8] The report also noted that state payments covered only 74 to 79 percent of provider program costs.
- As resources have become more limited, many states have sharpened and coordinated their mental health policy and organizational structures. Generally speaking, the mental health authority in most states, usually a DMH, focuses on providing legally mandated services (such as forensic services) and specialized recovery oriented services for individuals who are disabled as

[7] DHS-DMH is designated by the federal government as state's Mental Health Authority, which includes responsibility for planning mental health services. The Illinois Mental Health Planning and Advisory Council is responsible for advising DMH and other departments, divisions and agencies of state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof.

[8] Elizabeth T. Powers *et al*, *State Funding of Community Agencies for Services Provided to Illinois Residents with Mental Illness and/or Developmental Disabilities: Final Report to the Illinois General Assembly Requesters Pursuant to Public Act 93-842* (Urbana, IL: Institute of Government & Public Affairs, the University of Illinois, March 2007).

a result of mental illness. General outpatient services for people with mild to moderate conditions are provided through a network of primary care and outpatient providers. Inpatient psychiatric services are provided through a tightly managed Medicaid program. Responsibility for mental health services in Illinois continues to be uncoordinated and therefore diffused across multiple state agencies reducing efficiency and effectiveness. In addition, most states place the highest priority on services to individuals with the most severe illnesses. In Illinois, competition for mental health resources pits institutional care for the few with severe illness against community agency care for the many.

- The National Alliance for the Mentally Ill (NAMI) periodically grades state mental health services. In 2007, NAMI Illinois was one of eight states in the country graded at "F." In 2009, the NAMI raised Illinois's grade to a "D," (which was also the national average). It also issued a press release suggesting that the state was in danger of reverting to an "F." DHS-DMH notes that the issues addressed in the scorecard cut across most of the state agencies providing mental health services, making it difficult to pinpoint the areas or programs that should be priorities for improvement.

- While Illinois lags in total spending on mental health, the bulk of its investment goes to institutional care.[9] In FY 10 spending on community mental health services for 175,000 people (i.e., 96 percent of those served) totaled $390 million while spending on the 15,000 nursing homes beds that house people with mental illness who do not require daily skilled nursing totaled at least $640 million (or 59 percent of mental health revenue).

  As a result, community options for people with mental illnesses are more difficult to access than a bed in a nursing home, there are as many 15,000 Illinois citizens residing in nursing homes simply because they have a severe mental illness and more appropriate service options are not available and the state has had to defend itself in three federal lawsuits related to the use of institutional care versus community services.

- As Illinois has pursued a policy of maximizing Medicaid reimbursement for mental health services, many aspects of a Medicaid-driven, fee for service (FFS) system need to be addressed. For example, rates have not increased in at least five years and have been shown to provide about two-thirds of the actual cost of providing services. Unreimbursed, mandated administrative burdens and transaction costs associated with collecting FFS revenue have grown. Providers report that compliance risk is unevenly shared between the state and providers.

- DHS-DMH staffing has declined over the past eight years. This presents challenges, due to the inherent complexities of managing the state's mental health system.

- Recently passed nursing home reform legislation expands the pre-admission screening process and adds a re-screening component for nursing home residents with serious mental illness to help ensure individuals are provided with community options.

In addition to these system-wide challenges, there are several population-specific issues to note:

[9] Most other states have largely abandoned institutional care for people with severe mental illness except for forensic (i.e., legally mandated) cases and a very small group of individuals who present significant, real, and ongoing risk.

- Most other states have begun efforts to better integrate primary and mental health care. This is particularly important for individuals with the most severe illnesses. These individuals have a 25-year shorter life expectancy than the general population.[10] Illinois is also behind in integrating substance abuse and mental health systems of care and funding. It is the exception to find people without both of these issues yet services are funded and provided in silos, even though these individuals are recognized to be the system's most expensive consumers.

- Programs that support the transition to adulthood end at age 22, which raise issues of program integration and interagency coordination. Youths with mental illnesses age out of DCFS's system at exactly the period of development when, according to SAMHSA, mental illness has its highest prevalence. At the 18 – 21 year-old range, eligibility and diagnostic criteria for mental health services change; living arrangement options narrow and ongoing support shrinks.

- The Individual Care Grant (ICG) program, which allows youth with severe mental illness and their families to access mental health services, counseling, and residential care, has reduced its awards over the past few years. Also the reauthorization process has increasingly rejected some children who have been receiving mental health and residential services for years through this critical resource. As a result, families and youth with some of the most serious mental health needs have far fewer treatment options.

- Illinois has begun to increase its attention to prevention and early intervention of mental health needs in young children, including those who have increasingly displayed behavioral challenges that providers are not equipped to handle. Children are increasingly being removed from pre-school settings and early grade schools, underscoring the need for further family involvement, intervention and social-emotional learning in the schools.

  At the same time, there is broad acknowledgement of the need for trauma-informed practices amongst mental health providers. Much of the perplexing behaviors in youth can be traced back to a history of severe abuse, neglect and abandonment. This trauma affects all parts of a child's functioning and development. Providers are increasingly required to integrate a trauma-informed approach into their mental health treatment.

- For the thousands of people in Illinois who have co-existing disorders of mental illness and developmental disability, the system is currently structured to compel a "choice" of which issue is primary in order to access services. A person with, for example, schizo-affective disorder, PICA and mild mental retardation, could be placed into one or another system depending on how an evaluator interprets the primary problem. Depending on the evaluator's decision, the person will get some of the supports they need, but perhaps not others, unless they can successfully navigate between systems – which is a challenging task.

- Because of how the funding / reimbursement system is structured, providers are in effect incentivized to work with people who show up for care as opposed to those who are hardest to

[10] Joe Parks, MD, *et al*, editors, *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Directors Council, October 2006), page 11. Available at: http://nasmhpd.org/general_files/publications/med_directors_pubs/Mortality percent20and percent20Morbidity percent20Final percent20Report percent208.18.08.pdf

serve or only engage when outreach and other non-reimbursable services are also provided. This leaves those most in need of care cut off from access and more likely to utilize the emergency room, jails, etc.

- As previously noted, approximately 15 percent of DOC inmates have severe mental illnesses. Incarceration is not the ideal treatment setting for these disorders and when these individuals are released, they lack Medicaid to pay for services and medication, Social Security entitlements and access to a mental health provider. This dual, inside / outside disadvantage can lead to re-arrest and re-incarceration, at a cost to human lives that need rebuilding and taxpayer wallets.

- Veterans with mental health needs is an emerging issue that is currently addressed primarily through the Veteran's Administration (VA). The consequences of over 300,000 veterans with some level post traumatic stress disorder returning to civilian life will have some impact on community mental health systems nationally. Currently the VA, in conjunction with DMH, is leading the development of an appropriate, if still under-resourced, service response.

Other key trends that bear noting include the following:

- A positive development is that there are more effective interventions for serving people with severe mental illness than ever before. Current evidence-based practices have made the possibility of an independent life in the community a realistic hope for individuals with severe mental illness. It would require a state system organized and resourced to support widespread implementation of these practices; something seen in a more limited way in the successful implementation of evidence-base practices such as supportive employment and supportive housing by DMH. True-fidelity adoption of evidence-based practices generally includes costs that cannot be met with only Medicaid funding.

- Many states have begun efforts to better integrate primary and mental health care and Illinois is taking initial steps in this direction. This is particularly important for individuals with the most severe illnesses as they have a shorter life expectancy than the general population.

- Finally, going forward, it will be important to address the numbers and distribution of culturally competent providers, as for some linguistic, cultural, and ethnic minorities it is difficult to find providers who are able to deliver linguistically appropriate and culturally informed services.[11] Luis H. Zayas, PhD, of Washington University's St. Louis Brown School's Center for Latino Family Research reports, for example, that one in five U.S.-born Latina teens has attempted suicide, and that Latina teenagers have the highest rate of attempted suicide in the nation.

[11] A NAMI-produced mental health fact sheet takes a national focus on statistics related to mental health needs in the Latino community. It is available at the following link:
http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf

Human Service Category: Mental Health

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
Mental Health Services in Corrections System				
DOC	Sex Offender Treatment	To evaluate and treat inmates convicted or designated as sex offenders	To minimize risks to society on sex offender inmates that will one day be released back into society	$1,792,100
DJJ	Mental Health Treatment	To provide facility based mental health treatment to juvenile population	To address mental health issues that relate to the delinquency of youth committed to the Department's custody	$1,641,500
DOC	Services to Victims of Convicted Offenders	To provide assistance to victims of convicted offenders as needed	To help ease the minds of victims of crimes in regards to the potential release of his/her attacker	$62,900
DOC	Child Abuse Counseling	Treatment for female inmates that suffered from abuse at Dwight CC	To successfully treat inmates that suffered from abusive pasts	$31,000
Mental Health Services for General Population				
DHS-DMH	State Operated Facilities	DMH maintains nine state operated facilities that serve the State's forensic and civil populations.		$228,804,100
DHS-DMH	Medicaid billable services	These Medicaid billable services provides funding for recovery oriented services.	See Capacity Grants	$178,922,643
DHS-DMH	Capacity grants	Since not all community mental health services are billable, DMH awards capacity grants in order to allow community agencies to provide the full array of services to consumers.	DMH community agencies continue to provide recovery based services allowing consumers to participate fully in life in the community.	$125,000,000
DHS-DMH	Non-Medicaid	The purpose of non-Medicaid funding is to ensure the State's uninsured/under-insured population receive necessary community mental health services. In addition, these funds also provide vocational services	See Capacity Grants	$56,111,315

		and other evidence based practices that are not covered by Medicaid to Medicaid eligible consumers.		
DHS-DMH	Treatment & Detention	The Treatment & Detention Facility maintains the statutorily required Sexually Violent Persons program.		$27,627,500
DHS-DMH	Individual Care Grants	Funds residential treatment or specialized, intensive community mental health services to severely mentally ill children and adolescents.	See Capacity Grants	$27,550,500
DHS-CHP	Perinatal Depression		Improve Maternal Health	$296,000

Public Assistance

Overview

Illinois's human services system includes a set of income assistance programs that provide cash payments to low income individuals and families. Historically, these programs comprised the Illinois safety net, intended to help people meet their basic needs during periods when they had little or no income. In recent times, particularly since the welfare reform law of 1996, an additional purpose for some of these programs has been to mandate and support work activity.

The main program in this category, TANF, serves low-income children and families.[1] It has been dominated since welfare reform by administrative methods focused on caseload reduction, to the exclusion of both the safety net and the workforce support purposes. This trend has also been fed by the reductions in the state's human services workforce. The reduction in the workforce has corresponded to a dramatic increase in medical and food program caseloads, so that it has been hard for the department's staff to handle TANF applications timely, to cope with the flow of paperwork, and to provide individualized assistance. The remaining workers have little capacity or incentive to allow the TANF caseload to expand to respond to periods of high need. Thus, the program has continued to dwindle through the last two recessions and has not been available to help Illinois families cope with the current economic downturn.

Another major form of public assistance, one that relates to TANF,[2] is Illinois's child support system, which enforces the support obligations owed by noncustodial parents to their children. The Division of Child Support Enforcement (DCSE), in the Illinois Department of Healthcare and Family Services (DHFS) and its many partner federal, state, and local agencies and private entities does this by locating noncustodial parents, establishing paternity, obtaining child support orders based on state child support guidelines, collecting child support and distributing it to the child, taking enforcement actions when child support payments are not made timely and modifying child support amounts upward or downward as the paying parent's circumstances change. For many low and moderate income families, the child support program is an income maintenance program for children living in households where the parents are not living together.[3]

Other income assistance programs addressed in this section include Aid to Aged, Blind and Disabled (AABD), State Transitional Assistance, Refugee Income Assistance, State Family and Child Assistance and Circuit Breaker. Taken together, these programs were funded at $357,788,100 in FY 10, according to data provided by DHFS, the Department of Human Services (DHS) and the Department on Aging (DOA).

[1] See the Employment section of this report for a discussion of employment and training programs for TANF recipients.

[2] As a condition of receiving funds under the TANF block grant, the federal government requires every state to operate a child support program. The program is available free of charge to all families, although the public impression seems to be that it serves only families on cash assistance, that is, TANF, or that it gives such families priority service.

[3] It should be noted that the private dollars collected for child support are not "public assistance; " rather the services that make their collection are best classified in the public assistance area of this report, since they help families to maintain an income.

Populations Served

For the most part, the state's cash assistance programs were originally aimed at vulnerable or "deserving poor" populations, following the lead (and tapping the funds) of the various titles of the federal Social Security Act: children (TANF), caretakers of children (TANF), people at the end of life (AABD), people unable to work due to medical disabilities (AABD), and, later, refugees and asylees.

Illinois had a long tradition of safety net support for the lowest income individuals and families that did not fit into any of the federally-assisted categories, called the General Assistance program (GA). GA was delivered either through townships or by the state. It was largely abandoned in the budget crises of the late 80's and early 90's, leaving behind a handful of township-operated programs, and two rump state programs: State Transitional Assistance for adults with severe employment barriers (the vast majority being those with medical issues in the process of applying for federal disability assistance under SSI) and State Family and Children Assistance for the handful of families that for technical reasons do not fit into the TANF program. The result of the elimination of GA is that there are hundreds of thousands of deeply poor Illinois residents who are not eligible for any kind of state or local safety net cash assistance.

Today, Temporary Assistance for Needy Families (TANF) is the main cash assistance safety net program for children and their adult caretaker relatives. TANF was created by the massive welfare reform law of 1996, implemented in Illinois in 1997. It replaced the Aid to Families with Dependent Children (AFDC) program. It changed the funding scheme from an open-ended federal match (50 percent) to a block grant that was based on historic federal and state AFDC spending levels (that is, a block grant of federal funds conditioned on a state "maintenance of effort" obligation for spending of state funds). It imposed a lifetime 60-month limit on adult eligibility for federally funded benefits, and it instituted strict work activity mandates both on individuals and on the states (mandating that they have specified percentages of their caseloads engaged in work activities at all times). It instituted a bar on eligibility for noncitizens during their first five years in the country (undocumented people were already ineligible for AFDC). It rewarded states for caseload reduction, regardless of other family outcomes.

This focus on work activity was implemented in Illinois to make work preparation at least as strong a purpose of TANF as the safety net function and, for some people, TANF can function as an effective first step on the workforce ladder. But the caseload reduction impetus led to dramatic declines in caseload independent of whether former recipient families succeeded in the workplace. From 250,000 families on AFDC in 1995, the current TANF program has shrunk to just over 30,000 families today. TANF has proved insensitive to recessions or increased need. Caseload decline continued during the recession of the early 2000s and the first years of the great recession of the late 2000's, only recently ticking upward very slightly.

Moving from TANF to the child support system, while nationally the proportion of births to unmarried women increased in from 5.35 percent in 1960 to 36.8 percent 2005 (this despite a significant drop in teen pregnancy rates), in Illinois, the rate of births to unmarried women is even higher. Most unmarried parents who are not living together use the child support system to establish parentage and set, collect, and enforce support while most married parents who are not longer living together hire private attorneys to represent them in divorces proceedings which include establishing child support obligations.

There is no charge for child support services. In theory, all parents are eligible. Parents who apply for cash assistance from the TANF program are required to enroll as child support customers, unless they have "good cause" for not doing so. Currently more than one million children in Illinois are enrolled in the state's child support system. It is second only to the educational system as the government system that impacts the most children. Most of the 500,000 families who receive full enforcement services (that is, families that have applied for these services) are low income because of the mandate that TANF recipients enroll and because higher-income families are reluctant to apply, given the stigma associated with going to "public aid" as the old system was called.

In FY 09, DHF-DCSE served approximately 500,000 families and distributed 830 million dollars to families who received full enforcement services. The SDU (State Disbursement Unit) processes child support payments both for families that are enrolled in the child support program and for all families whose support is collected via income withholding by the payor parent's employer. In FY 09, the SDU processed about 1.4 billion dollars for all families through the central payment processing center required by federal statute.

With the decrease in the number of families applying for TANF, fewer families are being mandated into the child support program (although as noted elsewhere, the TANF caseload is increasing slightly in the current recession.) Nevertheless, it should be noted that low and middle income families could benefit from the services of the child support program. In fact, the current recession has led to increase in request for downward modifications of child support orders.

Service Delivery System

Public assistance programs are among those still delivered by the state employee workforce at DHS through community–based offices. This is traditional "welfare" work. Additionally, many nonprofits receive TANF-based grants to provide work-related services (like job search, basic education, transitional jobs, etc.).[4]

The AABD program was originally a federal-state program much like AFDC, providing cash assistance to the elderly and people with disabilities. In 1974, however, the program was federalized and became the Supplemental Security Income (SSI) program. States were mandated to hold people harmless in that transition, and so AABD became a state supplement to SSI. The people who receive AABD now in Illinois are those who have budgeted needs that exceed the monthly federal SSI payment amount.

The Refugee Income Assistance program is an entirely federally-funded program administered by Illinois. It supports refugees and asylees for a limited period of time after their arrival.

The Circuit Breaker program provides various forms of financial help to seniors and people with disabilities. Originally designed as a property tax relief vehicle, the program now is also the platform for prescription drug assistance as Illinois CaresRx. Circuit Breaker provides a convenient income screen

[4] TANF is an important source of funding for employment services, which are discussed in the Employment section of this report. DHS and employment and training provider agencies are both challenged to create employment and training placements for TANF recipients, who often face multiple barriers to employment.

and identification card, so it serves as eligibility proxy for such items as free CTA rides and energy assistance.

The Food Stamp program, now known as the Supplemental Nutrition Assistance Program (SNAP), cuts across all of these categories and provides monthly benefits delivered through LINK cards to help people buy food. The benefits are entirely federally funded, while the administration is federal-state. SNAP does not serve the undocumented or legal noncitizens during their first five years in the country. Everyone else, however, is eligible, including the GA population. In fact, SNAP program dollars support the Earnfare program, a workfare program that allows about 5,000 voluntary participants per month to earn cash on top of their SNAP allotments. (See the Food and Nutrition as well as the Employment sections of this report for more information about SNAP.)

DCSE is DHFS division responsible for the child support program in Illinois. DCSE and its many partners (listed below) locate absent parents, establish paternity, establish child administrative or court orders for child support through administrative and court proceedings, serve child support orders on employers, enforce child support orders through a wide array of court and administrative processes, collect and distribute child support, modify child support orders upward or downward due to changed circumstance for the payor of support, and, in some circumstances modify arrearages owed to the state. Services are delivered in many settings, but primarily in DCSE offices, in courts, in state's attorneys' and attorney general's offices.

DCSE works with parents and contracts with the following state, county, and private agencies to perform various processes: State's Attorneys, the Circuit Courts, the Expedited Child Support Divisions (in some counties), Clerks of the Circuit Courts, Sheriffs, the State Disbursement Unit (SDU), and private companies that help with specific tasks around reviewing child support orders and helping to collect support.

A larger array of other Illinois state agencies and constitutional offices are also involved: the Departments of Employment Security, Professional Regulation, Public Health and Revenue, as well as the Secretary of State, Attorney General, and Comptroller. Federal agencies involved in the child support system include the Departments of State, Health and Human Services (Administration of Children and Families), Treasury, and the Social Security Administration. Private attorneys and private child support collection agencies are also involved. Finally, hospitals assist in the paternity establishment process for newborns. In short, the child support system is very complicated.

Given this complexity, technology has been a great asset to improving accuracy and speeding up child support enforcement processes. DNA testing for paternity establishment, data match processing of newly hired people, and the interception of federal tax refunds have all improved the system. However, challenges remain and they include the following:

- The number of non-custodial parents who do not have income out of which to pay support. Such "unable to pay" parents include those who are temporarily unemployed, who are unable to work due to injury or illness, who are incarcerated, who face significant employment barriers due to criminal convictions or whose income is so low that they cannot meet their basic needs much less support a child.

- Collecting support from parents who are able but unwilling to pay support and are working off the books.

- Positioning the program to support parental involvement and reduce parental conflict.

- Dealing with the amount of child support owed to families and to the state (as reimbursement for cash assistance paid to families). Much of these child support arrearages are owed by very low income parents.

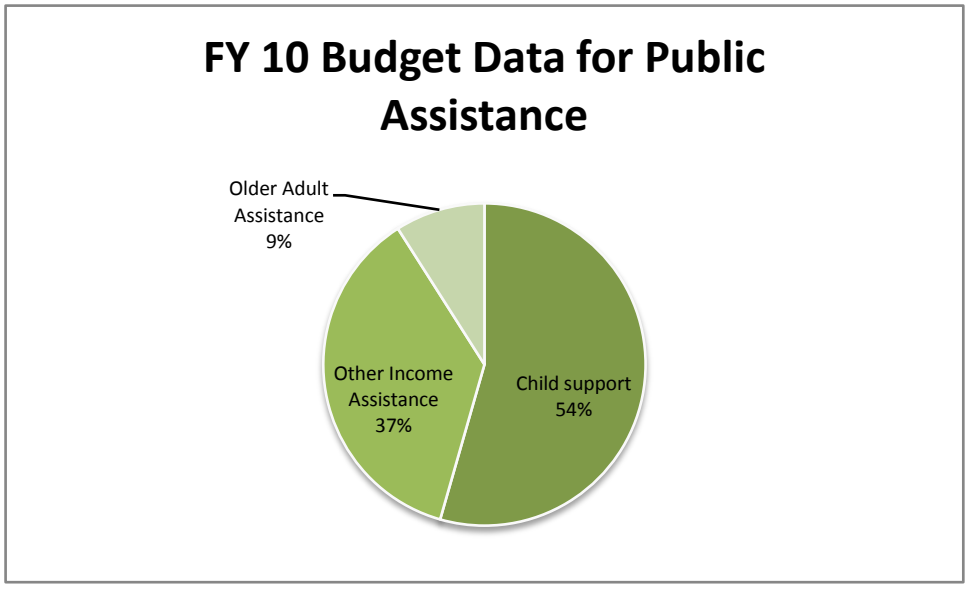
Funding

Public assistance programs under DHFS, DHS and DOA, were organized by three main categories (see tables at the end of this section details on program assignments) for this report. According to FY 10 budget data provided by these agencies, these programs reveal the following distribution of funding:

FY 10 Budget Data for Public Assistance

	Total
	$ 357,788,100
Child support	$ 194,758,900
Other Income Assistance	$ 130,742,300
Older Adult Assistance	$ 32,286,900

The nearly $357.8 million budgeted for public assistance is visually illustrated below:



The FY 10 and FY 11 budget crises are having little impact on the child support enforcement program because over 80 percent of the funding comes from the federal government in the form of matching funds and performance incentives payments and an increase is slated, as of this writing, for FY 11. In 2010 Illinois, aided by federal stimulus funds, implemented a long-overdue TANF grant increase. The grant levels continue to be among the lowest in the Midwest, still below 30 percent of the federal poverty level (FPL).

Currently, TANF and other core safety net programs are targeted for no growth, or for cuts. This has nothing to do with policy, but with the ongoing budget crisis and lack of adequate state revenues. SB 1800, signed into law by Governor Quinn in 2009, effective for FY 11, will change several of the procedural and financial practices in the TANF program that have kept caseloads artificially small. This would support a transition away from the current caseload reduction emphasis, to a focus on helping families navigate periods of deep need and productively launch themselves into the workplace. The bill received votes from both sides of the aisle in passing both chambers; however, implementation of this law is threatened in the proposed FY 11 budget.

It is important to note that the TANF scheme is a major source of funding for many programs other than TANF itself. The block grant is 585 million dollars, and the state maintenance of effort requirement is about 429 million dollars. In 2009, the TANF cash assistance budget line was about 90 million, including both cash assistance and related services, leaving around one billion dollars for other programs.

The federal TANF law allows federal and state funds to be spent on a very broad range of programs generally aimed at supporting children and families, and thus the TANF scheme is an important source of money for the child care subsidy program, large parts of the DCFS abuse and neglect system, MAP grants for student aid and many others. Illinois nationally is the lowest of all the states in spending its TANF block grant on actual TANF cash assistance to needy families during periods of temporary need. AFDC used to be the main between-jobs safety net for low income working women, who then and now are frequently unable to access Unemployment Insurance (due to technical eligibility rules for that program). TANF mostly fails to serve that purpose.

Critical Issues and Trends

An important demographic trend for at least a decade has been the growth of low-income working households, including employed households at or below federal poverty guidelines. SNAP caseloads have skyrocketed during the recession, an indication of the true level of need (and of the inadequacy of the TANF program to meet need). Illinois has received federal stimulus-backed assistance to address this. Some of those funds are being used to add 70 staff to the DHS workforce to timely process SNAP applications (as of this writing, hiring has only recently begun). Most of the money was used to pay increased costs for a private contractor that supports LINK cards. DHS is to develop a plan for additional dollars which can be expended through FY 11.

Since welfare reform, Family and Community Resource Centers have not been staffed at a level that allows the kind of intensive assessment and intervention work that would address barriers to employment such as mental health or substance abuse or domestic violence. The concept behind the state welfare reform law was that these interventions would help move individuals into paid work so they would not max out their 60-month lifetime limit. After the state early retirement program in 2002,

the vacancies created were not filled, under the reasoning that TANF caseload had fallen so dramatically that the former staffing levels were not necessary (even as SNAP and Medicaid caseloads have increased dramatically). This leaves us in the current situation where an influx of cases due to the recession swamps already overwhelmed offices.

An important feature of all of these programs is the effect of age transitions and the fact that public policy does not adequately address these transitions. Children eligible for many kinds of supports – TANF, Medicaid, child care, child support -- are suddenly ineligible for most of those same supports upon attainment of age 19. Parents eligible for supports because they care for minor children are suddenly ineligible for help unless they are disabled or age 65.

Illinois's child support program was once ranked by the US Department of Health and Human Services (HHS) as one of the poorest performing programs in the country. It has made significant improvements in HHS performance indicators, including paternity establishment, percent of current support collected, percent of cases with arrears with a collection of arrears, percent of cases with orders and cost effectiveness. For past several years, it has received national recognition for its improvement and received federal financial bonus payments for its performance.

Now that many of the operations within the DCSE have been streamlined (e.g., customers can access case information on line and via automated phone systems, many enforcement mechanisms have been automated, and DCSE is demonstrating improved outcomes in key performance indicators), DCSE and its Child Support Advisory Committee are thinking beyond the collection of money to how to change the system so that it respects and supports the active involvement of the "non-custodial parent" in the life his or her children and decreases hostility between parents.[5]

[5] Child support is a major source of tension for some parents. Parents think that the child support amount is unfair (too high or too low), that the child support is not used properly, that the child support is not paid consistently not because of inability but out of hostility, etc.

Human Service Category: Public Assistance Programs

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
Child Support				
DHFS	Child Support Enforcement	Establish legal parentage, establish and enforce child and medical support, locate parents and their employers, conduct review of order terms for modification, and collect and disburse support	1) percent of cases with orders, 2) percent of current support collected, 3) percent of cases with arrears with a collection of arrears,4) percent of paternity established, and 5) cost effectiveness	$194,758,900
Assistance for Older Adults				
DOA	Circuit Breaker/Pharmaceutical Assistance	Provides a property tax relief grant, prescription drug assistance, reduced license plate fees and disabled ride free cards to income eligible senior and disabled individuals throughout the state.	As a result of the property tax grant, seniors are able to stay in their homes as opposed to moving to a nursing home because of the rising costs or property tax. Also, the prescription drug assistance allows individuals to get necessary medicines without having to pass up food to do so. The reduced license plate sticker fee and the free bus pass allow individuals to safely and affordably get to places such as the grocery store and doctor's offices.	$30,686,900
DOA	SHAP Grants	Provides funding through the Tobacco Settlement Fund to link older adults to the Circuit Breaker/IL Cares Rx, Medicare Part D, Low Income Subsidy Program, and Medicare Savings Programs.	Links older adults to federal and state public benefits.	$1,600,000

Other Income Assistance

DHS-HCD	TANF	TANF is designed to temporarily provide cash assistance while a family moves to self-sufficiency. The Illinois TANF Program is designed to help needy families become self-supporting, strengthen family life, and reduce the instances of economic need in Illinois families.		$93,297,000
DHS-HCD	Aid to Aged, Blind and Disabled	The federal Supplemental Security Income (SSI) program pays a monthly grant to persons with low income who are certified as aged, blind or disabled		$29,214,500
DHS-HCD	State Transitional Assistance (GA)	General Assistance (GA) is mandated by State law and provides basic income and medical assistance to persons who are not eligible for TANF or AABD. The State Transitional Assistance Program covers adults without dependent children who have barriers to employment		$5,200,000
DHS-HCD	Refugee Income Assistance	Refugee Integration	Self-sufficiency and assimilation	$1,575,700
DHS-HCD	State Family & Child Assistance	General Assistance (GA) is mandated by State law and provides basic income and medical assistance to persons who are not eligible for TANF or AABD. I The State Family and Children Assistance Program covers needy families who do not meet the requirements to receive TANF such as caretakers who are not related.		$1,455,100

DHS-HCD	TANF ARRA	TANF ARRA Emergency Funds are available to States if they meet any of the following three conditions for a quarter during federal fiscal year 2009 or 2010:· The State's average monthly assistance caseload in the quarter is higher than it average monthly assistance caseload for the corresponding quarter of the TANF Emergency Fund base year, and its expenditures for basic assistance in the quarter are higher than its expenditures for such assistance in the corresponding quarter for the base year. The State's expenditures for non-recurrent short-term benefits in the quarter are higher than its expenditures for such benefits in the corresponding quarter of the Emergency Fund base year. The State's expenditures for subsidized employment in the quarter are higher than such expenditures in the corresponding quarter of the Emergency Fund base year. For each category above, a State that qualifies may request 80 percent of the amount by which expenditures in the quarter for which it is requesting funds exceed such expenditures in the corresponding base year quarter		

PUBLIC HEALTH

Overview

Illinois has over 200 public health programs, all of which shelter under the Department of Public Health (DPH). Of these, the largest programs focus on:

- Preparedness services, including those for bioterrorism and infectious diseases, that protect the general population's health: One of DPH's largest line items is the state's laboratory system. Funded $22 million in FY 10, the system tests for bacteria, viruses, parasites, environmental toxins and other health threats.

- Inspection services that protect people in a wide array of settings, including mobile home parks, milk processing facilities, restaurants and retail establishments, child care facilities, public pools and home healthcare. Funded just under $114 million in FY 10, DPH's inspection function includes two areas of note:

    - For nursing homes and other long-term care facilities, DPH operates an array of licensure, inspection, reporting, monitoring and investigative services. DPH is the Centers for Medicare and Medicaid Services delegate agency in Illinois charged with ensuring provider compliance with certification standards for key programs, which bring billions of federal dollars to our state every year. Taken together, these activities account for the largest share of DPH's budget, about $60 million in FY 10.

    - For Illinois' 90-plus certified local health departments, DPH expended $17 million in FY 10, enabling local offices in all regions of the state to carry out federal and state mandates, and provide public health education and programs in areas such as the water supply (public and non public, e.g., school and day care facilities), lead abatement, poison control and the prevention of birth defects.

- DPH also oversees an array of public education programs, another equally important core function. The largest programs focus on tobacco-free communities, HIV/AIDs prevention, breast cancer detection and education, particularly in communities where health disparities exist. A set of smaller programs address a wide array of other health problems, including asthma, Hepatitis C and Sudden Infant Death Syndrome. The smallest core area of DPH concerns research into a set of specific medical issues and problems: epidemiology, cancer, Lou Gehrig's disease, Alzheimer's and spinal cord injuries.

The State Health Improvement Plan has served as the state's method for trying to organize its public health efforts to reflect the best evidence available (such as Healthy People 2010) to secure the state's health. The plan requires the input of a wide variety of stakeholders from across the state. It is legislated to be updated once every four years and is undergoing its first update since the original legislation passed four years ago.

Populations Served

The benefits of public health programs are felt broadly. Clean drinking water, in particular, is a necessary good for all 12 million Illinois residents. Additionally, the assurance of a safe milk supply, clean public swimming pools and sanitary restaurant and retail establishments is a benefit that touches millions of people on a daily basis. Unlike means-tested human services programs, all residents – as well as tourists and other visitors to our state – benefit from these services.

Programs and services that insure the well being and safety of nursing home residents directly benefit the roughly 90,000 Illinois residents living in nursing home and other long-term care facilities.[1] The medically frail served in long-term care facilities, as well as their families, friends and other loved ones who care about them, taken together, constitute a large group that benefits from the state's ability to set and enforce federal and safety regulations for people served by these facilities. In addition, by ensuring continued Medicare and Medicaid funding, these programs benefit all Illinois taxpayers.

Service Delivery System

The site-specific nature of many public health activities requires specialists who work in the field, inspecting, monitoring and evaluating both facilities and their personnel. Other services require both field and laboratory work – to collect and test water samples, for example. These also require highly trained personnel. Both field and lab work require back office capacity as well: to compile and analyze statistics, prepare reports for state and federal agencies and maintain records. Public education programs frequently are delivered in community based settings.

The service delivery system benefits from a significant federal contribution to healthcare in the state. Federally Qualified Health Centers and other "look-alike" designated clinics serve to reach underserved populations in many of the urban and rural areas of the state. In Illinois, community health centers (CHCs) serve as the medical home for over one million patients, with a plan to double this number by 2015. Forty-seven percent of them are enrolled in Medicaid, Family Care or the All Kids program; 32 percent have no health insurance at all. The state provides capital support for start-ups or building improvements through the state budget. Federal Health Reform has provided several billion for the expansion of CHCs throughout the US over the next several years.

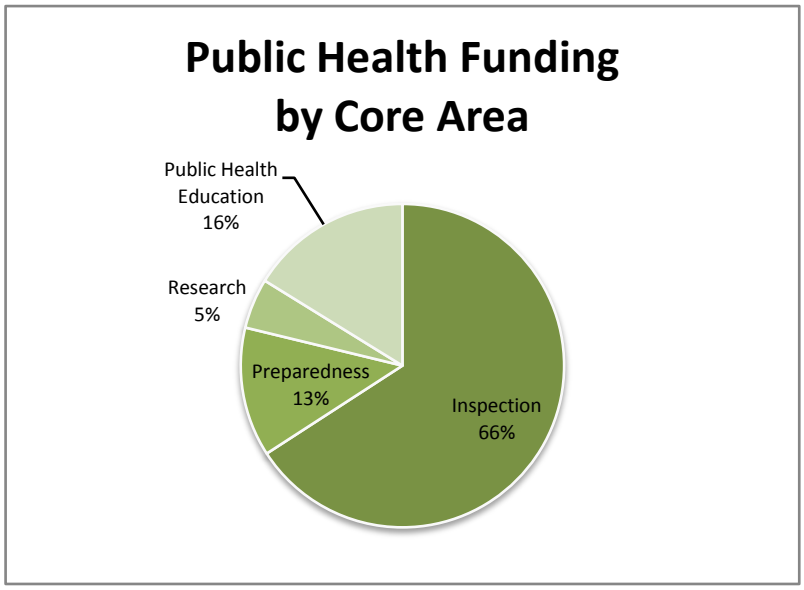
Funding

FY 10 budget data provided by DPH show spending by the four core areas of public health: inspection, preparedness, research and public health education.

[1] According to the Nursing Home Safety Task Force's *Final Report* dated February 19, 2010 report, there are over 1,200 DPH-licensed long-term care facilities in the state with 121,811 beds; roughly 75 percent of these beds are occupied (Appendix 2, page vi).

FY 10 Budget Data for Public Health	
	Total
	$172,825,989
Inspection	$113,808,400
Preparedness	$22,357,500
Research	$8,673,400
Public Health Education	$27,986,689

These figures are visually illustrated below:



These programs are funded by a combination of General Revenue dollars, Medicare and Medicaid funds, and fees.

Critical Issues and Trends

Two public health issues – diabetes and obesity – are funded by DPH but arguably at levels that do not match the growing scope and perils associated with these problems. However, an understanding of the various local efforts, including those of philanthropy and other funders should be considered for study to understand the potential for public/private partnerships to address these issues.

Illinois ranks near the top for states for the percentage of residents living in nursing homes and other long-term care facilities institutions as opposed to community-based settings. This results in higher costs for Medicare and particularly Medicaid costs to the state (for reasons that include, in part, the cost of licensure). The ACLU and other non-profit organizations have several pending lawsuits that would

allow residents the choice of living in a nursing home or in assisted or supportive living settings. The outcome of these legal actions could significantly change the number of residents in nursing homes and the amount that we spend as a state to regulate the entity.

Demographic changes will also play strongly into this area: As baby boomers age, the number of senior citizens is projected to grow significantly in Illinois over the next 30 years, to nearly 20 to 25 percent of the population. Depending on future public policy direction, this could mean either explosive nursing home growth – and the associated costly regulatory practices – or it could push Illinois to act, as many other states have, to create more community based living opportunities that allow older persons to age in place. The burden of chronic disease in this population (up to 60 percent of people over 65 are living with one or more chronic conditions such as arthritis, diabetes, etc) is a consideration for future planning efforts, in order to minimize the impact these conditions on the ability to age independently.

Nursing home reform legislation was recently passed in Illinois that will strengthen penalties and fines to nursing homes for failing to meet standards. The legislation also expands the Department of Public's Health authority to suspend, revoke or refuse to renew a facility's license.

Technological advances, including the electronic storage and transmission of health data (EHR: Electronic Health Records and HIE: Health Information Exchange), could potentially streamline communication between laboratories, local health departments and other entities that communicate population-based data. Depending on the resources available to achieve near-universal adoption of these technologies, this could results in cost reductions while preserving core functions of public health services.

Human Service Category: Public Health

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
Inspection				
IDPH	Division of Long Term Care			$31,333,000
IDPH	Nursing Home Licensure	Establishes standards and perform inspections and complaint investigations to determine compliance with state law and rules for the various levels of care.		$17,563,400
IDPH	Local Health Protection Grants	Administers local health protection grants for population based communicable disease prevention programs. Activities include rulemaking; development, support and enforcement of the standards; formula development, revision and implementation; and payments to local health departments in support of their food, water, private sewage and communicable disease programs.	1) Provided $13,981,400 in grant funding for FY 03 to 94 local health departments. 2) Provided resources to support the regulation of over 45,000 food establishments; for inspection of over 10,000 water wells and 17,000 private sewage systems; for investigation of thousands of reported communicable diseases; including West Nile Virus. (FY 02)	$17,098,500

IDPH	Nursing Home Certification	Conducts certification surveys in long term care facilities as authorized by the Centers for Medicare and Medicaid services (CMS) to determine compliance with federal requirements.	1) The Illinois LTC certification program continues to be a national leader in the number of enforcement actions taken against non-compliant nursing homes. Due to the increasing complexity of the federal regulations and the increase in the public concern and scrutiny of the performance of nursing homes, the LTC program has initiated a series of forum meetings with the regulated industry. The purpose of the meetings is to educate the facility administrations and staff as to the regulations and the survey process. It is the program's intent to improve compliance through both increased enforcement and industry education. Similar efforts are underway for providing education to resident families and other consumers of LTC services in Illinois. Corrective action plans were required for only three (3) of 12 performance measures.	$9,972,200

IDPH	Environmental Lead	Issues licenses for occupations involved in performing lead inspection, abatement and mitigation in activities in dwellings and child care facilities; approves lead training course providers who offer training to individuals seeking accreditation and/or licensure; conducts lead investigations of dwellings and child care facilities to identify and eliminate environmental lead hazards which are sources of lead poisoning; and, provides financial assistance for lead-based paint hazard reduction to low-income families. Provides case management services for children with elevated blood lead levels in Illinois counties that do not provide case management services. Maintains surveillance database for children identified with elevated blood lead levels.	The Department licenses inspectors, risk assessors, contractors, supervisors, and workers after they have demonstrated their competence by completing department approved training courses and passing the examination. Inspections are conducted of the dwelling of lead poisoned children and remedial measures to eliminate the hazards are required of the owner. (FY 09)	$4,932,100
IDPH	Get the Lead Out	Provide lead-based paint hazard identification and remediation services to low-income families in targeted areas through local housing and health agencies.	Through a grant for HUD , 81 dwellings have had lead paint hazard identification and reduction services during the period July 1, 2008 through June 30, 2009 (figures are actually up through May 09). (FY 09)	$3,443,000
IDPH	Dairy Farm, Milk Transportation and Processing Plant Sanitation	Issues permits or licenses and performs inspections, reviews and evaluations for Grade A and manufactured farms and processing plants, milk tank truck and bulk milk hauler/samplers; and collects samples for laboratory analysis and tests pasteurization equipment.		$3,216,000

IDPH	Poison Control Centers	Designates, regulates and coordinates statewide poison treatment program.	The Illinois Poison Center provided comprehensive poison center services for all of Illinois during the reporting period. Launched Spanish language web site for the public in January, 2007 The Illinois Poison Center partnered in a pilot program to manage the city of Chicago Chem.-Pack program for a limited time should there be an event until the city EOC is up and can manage the inventory. (FY 07)	$2,201,500
IDPH	Plumbing and Lawn Irrigation Registration	Conducts examinations, licenses plumbers and apprentice plumbers, registers Irrigation contractors and plumbing contractors, performs inspections of plumbing installations, identifies and initiates enforcement action against individuals doing plumbing procedures without a license, approves plumbing continuing education sponsors and courses, provides continuing education programs to licensed plumbers, and conducts the registration of irrigation and plumbing contractors.	The Department licenses approximately 8,729 plumbers and 2,466 apprentices. 266 Certified Plumbing Inspectors, 2,000 Irrigation Employees, 2,974 plumbing contractors, 343 irrigation contractors each year. State plumbing inspectors conducted 21,889 inspections including 2,587 long-term care facilities and 1,598 in hospitals. 1,233 examinees were tested for a plumber's license. Seminars and meetings were conducted by state plumbing inspectors for plumbers, apprentices and governmental agencies. (FY 09)	$2,197,500
IDPH	Hospital and ASTC Plan Review	Conducts plan reviews and inspections for hospitals and ambulatory surgical treatment centers.	1,476 plan reviews were completed, 407 licensure surveys conducted, 5,099 pieces of correspondence were responded to. All tasks were accomplished within the mandated time frames. (FY 08)	$1,700,000

IDPH	EMS Professional Licensure Education and Testing	Performs and coordinates educational development and testing of potential EMS licensure candidates and coordinates continuing education programs.	The State of Illinois Emergency Medical Technician (EMT) and Trauma Nurse Specialist (TNS) exams continue to be produced, administered, analyzed and processed by Continental Testing Services, Inc. The members of the testing writing review panels continue writing, reviewing and validating questions for the exams. (FY 08)	$1,423,000
IDPH	Hospital Certification	Conducts surveys as requested or in response to complaints--acting as an agent for the Centers for Medicare and Medicaid Services Authority--to determine compliance with federal requirements.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements (FY 08)	$1,155,900
IDPH	Swimming Facilities	Conducts inspections, and reviews plans for construction of swimming pools, spas, water slides, and bathing beaches and issues permits to assure compliance with the Administrative Code.	1) The Department and eight approved local health departments regulate public swimming pools, spas, bathing beaches, and water slides to assure they provide a safe and sanitary environment for patrons. 2) All bathing beaches are sampled every two weeks for bacteriological quality to assure that they are not contaminated. (FY 08)	$1,140,000
IDPH	Home Health Certification	Conducts inspections and complaint investigations--acting as an agent for the Centers for Medicare and Medicaid Services (CMS)--to determine compliance with federal requirements.	Monitoring for compliance with certification, evaluation of complaints and recommendations as appropriate. (FY 08)	$1,135,300

IDPH	Asbestos Abatement	Issues licenses for occupations involved in performing asbestos abatement in schools, commercial and other public buildings; conducts inspections of abatement projects; reviews asbestos management plans for schools; approves asbestos training providers; and conducts inspections of schools to determine compliance with state and federal laws.	1) Nearly 4,938 public and non-public schools have employed licensed asbestos professionals to ensure that their buildings are inspected for asbestos. With the aid of the Department, the schools properly manage the asbestos containing materials in their building and conduct asbestos abatement projects when these materials must be removed. 2) Approximately, 857 asbestos abatement projects were conducted in schools to remove asbestos containing materials. The Department ensures that projects are conducted in a manner that protects the public health and reports are completed and submitted for review. 3) Approximately 7349 people were licensed by the Department to conduct asbestos related work in schools and commercial and public buildings after demonstrating that they had met the minimum experience and training requirements. (FY 09)	$1,093,900

IDPH	Food Processing	Inspects food processing plants and warehouses; conducts surveillance food sampling; investigates consumer complaints; issues advisories and recalls; and issues Certificates of Free Sale for Illinois firms who wish to export their products to foreign countries.	1. Inspection and sampling of Illinois manufactured or processed foods, I.e., microbiologically sensitive ready-to-eat foods for vending, apple cider, bottled water, processed vegetables; pesticides on fruits and vegetables, smoked fish, etc. identifies trends in food safety. 2. Use of a risk-based seafood and fish processing inspection program based on Hazard Analysis Critical Control Point (HACCP) concepts which includes one of the few shellfish firm certification programs for non-producer states, provided low cost training to seafood and fishing industry. 3. Provided Certificates of Free Sale to Illinois firms who wish to export their products to foreign countries (1164 requests asking for 4,570 certificates in FY 08.) 4) Continuation of low acid canned food (LACF) and acidified canned food (ACF) inspections through a partnership agreement with FDA, specialized training for field staff and searches for uninspected LACF/ACF firms within the State. (FY 08)	$1,092,000

IDPH	Environmental Toxicology	Assesses environmental data to determine whether a public health hazard exists for persons exposed to contaminated environmental media; educates persons on ways to reduce exposure to environmental contaminants; responds to inquiries regarding chemical exposures and possible human health effects; and evaluates health-related complaints involving indoor environmental issues.	Evaluated the health implications of environmental exposure to hazardous substances throughout the state. Evaluations included exposures related to hazardous waste sites, household chemicals, mold and indoor environments, and former methamphetamine properties. Program staff also assisted with the Department West Nile virus response, and was recognized by the federal Agency for Toxic Substances and Disease Registry as a national leader in the public health assessment of hazardous waste sites. (FY 08)	$1,075,000
IDPH	Hospital Licensure	Establishes standards and performs inspections and complaint investigations to determine compliance with state law and rules.	Conducts inspections and complaint investigations to determine compliance with state requirements (FY 08)	$956,500
IDPH	Home Health, Home Services, and Home Nursing Agency Licensing	Establish home health licensure standards, and perform inspections and complaint investigations to determine compliance with state law and rules. Public Act 94-379 requires the licensure of home services agencies and home nursing agencies on and after September 1, 2008; provides for the licensure of such agencies in conjunction with the licensure of a home health agency. On or before July 1, 2007, the Committee shall issue an interim report to the General Assembly on the status of development and implementation of the rules for home services agency and home nursing agency licensure.	Conducts initial licensure surveys and complaint investigations (FY 08)	$953,500

IDPH	Non-Community Public Water Supply	Reviews construction plans for compliance with rules and regulations; inspects and samples water supplies that serve 25 or more non-residential persons (schools, daycares, campgrounds, restaurants, etc.) for at least 60 days per year to ensure that they meet certain water quality standards; and provides grants and training to local health departments to conduct the program.	The Safe Drinking Water Information System (SDWIS) Database continues to be fully implemented for management of Program data including the following four accomplishments: 1) Complete reporting of required data reported to USEPA each quarter. 2) Quarterly letters are sent to all 402 non-transient non-community public water systems to provide them an updated schedule for their 68 chemical contaminant sampling requirements. 3) The compliance decision support module is run each quarter for all 402 non-transient non-community public water systems to determine compliance with their 68 chemical contaminant sampling requirements. 4) Compliance reports are generated quarterly and as needed to determine compliance with Coli form Bacteria and Nitrate monitoring requirements for all 4132 non-community public water systems. In addition program training was provided to Local Health Departments as requested by Regional Offices. (FY 09)	$720,800
IDPH	EMS Systems	Regulates emergency medical services in Illinois.	Grants are awarded each year from the EMS Assistance Fund to EMS agencies in each of the 11 EMS Regions. 41 agencies received $66,000 in grants. (FY 08)	$692,800

IDPH	Food Service Sanitation Manager Certification	Develops and administers examinations for individuals to become certified food service managers; approves and trains instructors; issues certificates; and approves other commercial food service examinations.	1. 373,180 food service managers are currently certified utilizing training and testing of food safety knowledge and apply that training while working in the food service industry in Illinois. 2. Mailed out and received back approximately 30,000 exams/materials. 3. Twelve statewide trainings for Food Service Sanitation Manager Certification (FSMC) instructors were held to upgrade instructor skills in training food safety and sanitation - 466 instructors attended. 4. There are currently 615 individuals who are approved to teach the food service manager training course in the state. 5. Continued conducting FSSMC instructor testing and training in Springfield. (FY 08)	$603,000

IDPH	Structural Pest Control	Licenses and inspects structural pest control companies and individuals who apply pesticides in, on or under structures to ensure safety standards are maintained. Effective August 1, 2000 (P.A. 91-525) and July 1, 2004 (P.A. 93-0381) public schools and licensed day care centers (LDCC) were required to adopt an integrated pest management program that incorporates guidelines developed by the Department unless they can demonstrate to the Department that to do so would be economically unfeasible. School districts and LDCC's must notify parents, guardians and employees on their registry (or in the absence of a registry, everyone) of all pesticide applications (excluding insecticide and rodenticide baits) at least two business days prior to the pesticide application. In August 2008, schools and LDCC's are required to notify the Department every five years that they have implemented an IPM program and, if not, attend an IPM training seminar within the same time frame. Schools and day care centers must have their plan available for public review.	1) The Department licensed/renewed structural pest control businesses, registered/renewed non-commercial locations where restricted use pesticides are used (food plants, wood treatment facilities, housing authorities, etc.) by in-house certified technicians and examined/renewed technicians to assure the proper formulation and use of pesticides. 2) The Department inspected licensed/registered pest control businesses and their technicians in actual field accounts, inspected facilities where pesticides are sold to consumers, and responded to complaints alleging the misuse of a pesticide or those operating outside of the law. 3) The Department monitored/participated in presentations given by a grantee to schools and day care centers pertaining to IPM. (FY 09)	$599,200
IDPH	End Stage Renal Disease Facilities Certification	Inspects to recommend certification and recertification for Medicare certified dialysis facilities. In addition conducts complaint investigations.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements. (FY 08)	$584,800

IDPH	Adverse Pregnancy Outcomes Reporting System	APORS is one component of the Illinois Health and Hazardous Substances Registry. APORS collects information on Illinois infants born with birth defects or other abnormal conditions. The purpose of APORS is to conduct surveillance on birth defects, to guide public health policy in the reduction of adverse pregnancy outcomes and to identify and refer children who require special services to correct and prevent developmental problems and other disabling conditions. Mandated reporting was initiated in 1989.	APORS was recognized by the National Birth Defects Prevention Network for developing a new training method (self-directed training video in FY 08). APORS distributed more than 14,500 pieces of information for promotion of healthy pregnancies to colleges, hospitals, local health departments and statewide conferences.(FY 09)	$554,700
IDPH	Clinical Laboratory Certification	Conducts inspections and complaint investigations of all laboratories, including blood banks.	1) Monitoring for compliance with certification, evaluation of complaints and recommendations as appropriate; 2) Provided quality assurance review to Clinical Laboratory management. (FY 07)	$506,900
IDPH	Assisted Living, Shared Housing and Board & Care Homes	Permits the development and operation of assisted living and shared housing establishments for senior citizens. Assisted living and shared housing establishments provide residential accommodations and specified services to seniors, including meals, housekeeping, security, and necessary assistance with activities of daily living. Requires Assisted Living and Shared Housing facilities to be licensed and establishes license requirements. Effective on January 1, 2006, Board and Care Homes are required to be registered with the Department.	Conducted approximately 350 on site surveys for 251 facilities. (FY 08)	$478,100

IDPH	Mobile Home Parks (Manufactured Home Communities)	Reviews plans for the construction or alteration of mobile home parks and conducts annual inspections for proper water supply, sewage disposal, electrical system and other health and safety requirements to assure compliance with the Administrative Code.	1) The Department regulates mobile home parks (manufactured home communities) except that those in home rule units are exempt. Licenses are issued when the water supply and sewage disposal systems, lot requirements, streets, lighting etc. are found to provide a safe and sanitary environment for the residents. 2) Construction permits for alterations or expansion of existing parks or construction of new parks are issued to assure that construction will be in compliance with the code. (FY 09)	$475,000
IDPH	End Stage Renal Disease Facilities Licensure	Licensure program for end stage renal disease facilities. All end stage renal disease facilities in existence as of the effective date of this Act shall obtain a valid license to operate within one year after the adoption of rules to implement this Act.	Program in implementation phase (FY 08)	$385,000
IDPH	Private Sewage Disposal	Issues licenses for private sewage system installation and pumping contractors, reviews plans for the installation of systems and provides consultation and training for local health departments conducting the program. Public Act 94-138 added licensure requirements for the pumping, hauling, and disposal of wastes removed from the sewage disposal systems of portable toilets.	1) The Department continues to license private sewage disposal installation contractors and pumping contractors who have demonstrated their competency by passing an examination. 2) The Department has worked with stake holders to develop the proposed amendments to the Private Sewage Disposal Code 2003. 3) The Department has been reviewing and approving alternative technology under the new amendments to the Private Sewage Disposal Licensing Act. 4) Subsurface drip disposal was recently approved giving more	$350,000

			options for sites with restrictions and limitations. (FY 09)	
IDPH	Ambulatory Surgical Treatment Center Licensure	Establishes standards and performs inspections and complaint investigations to determine compliance with state law and rules.	Conducts initial licensure surveys and complaint investigations (FY 08)	$264,600
IDPH	Tanning Facilities	Establishes operational, record keeping, sanitation, operator training and other standards for tanning facilities and issues permits and provides grants to local health departments to conduct annual inspections.	1. Over 5,500 tanning facility licenses issued with 1,800 currently active. 2. 81 local health departments have signed contracts with the Department to conduct tanning facility inspections in 92 counties. 3. Training is provided for local health department personnel at least twice a year. Two-day seminars teach new sanitarians proper inspection techniques, and make them aware of risks associated with ultraviolet radiation. Approximately 950 local health department sanitarians have participated in these seminars, since the beginning of the program. (FY 08)	$252,000

IDPH	Long-Term Care Facility Plan Review	Conducts plan reviews of new and remodeled long-term care facilities.	1) The Department is currently meeting or exceeding mandated timeframes for review of construction plans. 2) The Department offers in-house review of preliminary construction plans which allows design flaws to be identified early in the design process. (FY 08)	$250,000
IDPH	Ambulance Licensure	Inspects and licenses ambulances--including specialized emergency medical vehicles--and awards equipment grants using the money from annual license fees that are deposited in the EMS Assistance Fund.	Licensure database is completed and functional. The department is working towards securing pda's for in-field electronic inspection reporting. (FY 08)	$246,100
IDPH	Campgrounds/Recreational Areas	Reviews construction plans, issues licenses and inspects facilities for compliance of water supply, sewage disposal and electrical systems, and food handling procedures and facilities.	The Department regulates campgrounds to assure that the water supply and sewage disposal systems, food service operations, swimming facilities and other camp facilities provide a safe and sanitary environment for campers. (FY 09)	$240,000
IDPH	Private Water Supplies (Water Well Construction, Drillers and Pump Installers)	Issues permits, inspects and samples new water wells to ensure proper construction; provides grants and training to local health departments to conduct the program; and issues licenses for water well drillers and pump installation contractors.	1) The Department and local health departments issued approximately 3,500 water well construction permits during FY 09. Since 1988 when the permit program became a responsibility of the Department, approximately 134,000 permits have been issued. These permits help assure that new well and pump installations will be constructed properly and provide safe drinking water. 2) Approximately 2,000 abandoned wells were sealed during FY 09. Since 1988, approximately 50,000 abandoned wells have been sealed, eliminating safety hazards for	$214,000

			small children and routes of groundwater contamination. 3) Water Well and Pump Installation Contractors who have demonstrated their competency by a combination of experience and passing an examination are licensed by the Department. (FY 09)	
IDPH	Ambulatory Surgery Center Certification	Conducts inspections and complaint investigations - as an agent of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid - to determine compliance with federal Medicare requirements.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements (FY 08)	$206,400
IDPH	Abuse Prevention Review Team Act	Abuse prevention review teams composed of individuals from multi-disciplinary and multi-agency entities are to be developed to review sexual assault of nursing home resident cases and unnecessary deaths of nursing home residents. The purpose of the review is to assist the state and counties in investigating sexual assaults and deaths, as well as develop a greater understanding of the incident and causes of resident sexual assault and deaths of nursing home residents. Identification of methods for preventing those assaults and deaths and identify gaps in the services to nursing home residents will also be identified.	February 2008 through June 2008 the team was completed with a Nurse Manager, 2 Health Facility Surveillance Nurses and an Executive 1. The logging and tracking system was set up along with establishing areas the team would focus on and outcomes of surveys to be taken on to the quarterly meetings for further review. (FY 08)	$200,000
IDPH	EMS Professional Licensure (EMTs, TNSs, First Responders, et al.)	Focuses on activities associated with the licensure of emergency medical technicians, emergency communications nurses, dispatchers, lead instructors, first responders, pre-hospital nurses and trauma nurse specialists.	The automated download of State of Illinois exam results into the EMS database was put into production. The EMS database was expanded to include additional information pertaining to licensed individuals. (FY 07)	$195,000
IDPH	Community Living Facilities	Establishes standards and performs inspections and complaint investigations to determine compliance with state law and rules.	Conducted all licensure surveys in accordance with state licensing requirements. (FY 08)	$187,000

IDPH	Census of Fatal Occupational Injuries	CFOI collects information and verifies all occupational fatalities among Illinois residents. This program is mandated by Public Law 91-596. Fatal work injuries and illnesses can often be traced to hazardous working conditions. Data from CFOI provide specific information on how the injury occurred and certain characteristics of the fatally injured person. These data are then used to improve working conditions.	Data collection for FY 09 was completed within the timeframe set by BLS and a summary report for 2007 data is in process. (FY 09)	$185,000
IDPH	Nurse Aides Training	The Education and Training component of the Training and Technical Direction Unit approves Nurse Assistant Training Programs, Instructors and Evaluators; monitors programs for compliance with Licensure Regulations; works with Health Care Worker Registry staff and SIU-C Competency Testing program staff who administers testing statewide. Program oversees Train-the-Trainer courses and Evaluator Workshops conducted by Community Colleges, both of which are required for approved Instructors and Evaluators of Nurse Aide Training Programs.	Revised/updated the Performance Skills Manual; approved 47 new Nurse Aide Training Programs; reviewed approximately 850 Master Schedules and Rosters, conducted 15 Monitoring visits of programs, approved 175 Instructors and Evaluators. (FY 08)	$180,400

IDPH	Retail Food (Food Service and Food Store)	Promulgates rules and regulations, develops educational materials, and provides training, standardization, consultation and interpretations to local health departments to ensure that the preparation, packaging, storage, and distribution of food intended for sale is accomplished under safe, sanitary and clean conditions.	1. Training for new and existing local health department staff, standardizations of Food Inspection Officers, food program and local ordinance reviews against mutually agreed upon standards and support for ninety-six certified local health departments. 2. Promulgation of rules for retail food establishments and enforced by local health departments that are routinely updated to reflect changes in the industry operations, interpretive guidelines, assistance approving HACCP Plans and other information to support local retail food safety programs. 3. An emergency response system that includes food borne illness and consumer complaint investigations, recalls, embargoes, truck and common carrier accident investigations that are documented in an electronic incident system and liaison with other state and federal agencies involved in these incidents. 4. Staff participated in two table top exercises for food emergency response. 5. Program participates in the FDA Retail Food Program Standards. (FY 08)	$160,000
IDPH	Hospice Licensure	Establishes standards, and performs inspections and complaint investigations to determine compliance with state law and rules.	Conducts initial licensure surveys and complaint investigations to determine compliance with state regulations (FY 08)	$151,200

IDPH	Smoke Free Illinois	To improve the health of Illinois citizens by reducing exposure to secondhand smoke and by responding to complaints provided reporting violations of the Smoke-Free Illinois Act (SFIA), originally enacted January 1, 2008 (formally the Illinois Clean Indoor Act), and was amended effective February 4, 2009. Prohibits smoking in public places, places of employment, and governmental vehicles. Requires "No Smoking" signs to be posted in each public place and place of employment where smoking is prohibited. Requires ashtrays to be removed from any area where smoking is prohibited. The SFIA requires that the Department of Public Health, State-certified local public health departments, and local law enforcement agencies shall enforce the provisions of the Act. The Act sets forth fines for violations of the Act. The most important revision in the amended Act is that it changes a violation from a criminal act to a civil offense. A key component of the new law was the inclusion of a provision to allow violators to appeal a citation. It states a violator can submit a request for hearing to contest the imposition of a fine to the enforcing agency, which will then forward a copy of the request to the Department for a hearing. The Department will notify the violator, in writing, of the time place and location of the hearing, which will be held at the nearest Department regional office. The law also gives the Department the option to hold hearings in the county where the citation was issued.	From January 1, 2008 through March 31, 2009, a total of 6,710 complaints were filed with the Department of the Smoke Free Illinois Enforcement System. total of $1,550 in fines has been collected to date, but it is anticipated that the amount of fines collected will increase substantially, due to the amended law. (FY 09)	$150,000

IDPH	Trauma Centers	Evaluates trauma centers' operations to determine the designation and redesignation of the level of service each center is authorized to provide and maintains a Trauma Registry.	Five trauma center site surveys were conducted and approx. 25 revised trauma plans were reviewed and approved. All Illinois trauma centers are required to submit data to the Department via the web-based Trauma Registry. Approx. 35,000 cases are submitted each year. Data collection was added to meet the requirement that a trauma center that treats any person under the age of 18 years for injuries suffered in an accident involving a motor vehicle backing over a child or the power window of a motor vehicle must report the accident to the trauma registry. (FY 06)	$138,000
IDPH	Rural Health Clinics	Conducts Medicare certification inspections and complaint investigations.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements. (FY 08)	$137,600
IDPH	Automated External Defibrillator	Provides for the regulation of training requirements and use of automated external defibrillators. IDPH is to collect incident reports on automated external defibrillator use through the EMS Systems.	Public Act 95-0447 removed the requirement that all AEDs be registered with a Resource Hospital and that AEDs be used only be trained users. (FY 07)	$122,500
IDPH	Hearing Instrument Consumer Protection	Licensing of hearing instrument dispensers, evaluation of skills and knowledge prior to licensure, mediation of consumer complaints, administrative action against licenses, as necessary.	* 61 written examinations given * New dispensers licensed- 23 * Dispenser licenses renewed - 164 * Complaints investigated - 5 * Dispensers currently licensed in Illinois - 340 (FY 09)	$104,000

IDPH	Community Water Fluoridation	Monitors the fluoride level in community water systems; provides education, recognition of excellence and technical expertise to water system operators to keep fluoride levels optimal; educates local health departments, dentists, and dental hygienists regarding fluoridation; and provides information to the general public regarding the efficacy and safety of water fluoridation. Provides water system fluoride status to Illinois Environmental Protection Agency quarterly and to the Centers for Disease Control and Prevention annually.	In 2007, 92 percent of the 12,852,548 residents of Illinois were served by a public water supply. Of those 11,781,807 residents, 99 percent receive fluoridated water. (FY 08)	$70,000
IDPH	Hospice Certification	Conducts inspections and complaint investigations--acting as an agent for the Center for Medicare and Medicaid Services--to determine compliance with federal requirements.	Conducts inspection and complaint investigations to determine compliance with federal certification requirements (FY 08)	$68,800
IDPH	Youth Camps	Reviews plans, licenses and inspects youth camps for compliance with sanitation, water supply, sewage disposal, electrical systems, swimming facilities, food service operations and other features to assure a safe and sanitary environment for campers.	1) The Department regulates youth camps to assure that the water supply and sewage disposal systems, food service operations, swimming facilities and other camp facilities provide a safe and sanitary environment for the children. 2) Plans for alterations to existing youth camps or construction of new camps are reviewed and permits are issued to assure that construction will comply with the code. 3) All deaths, and illnesses and injuries that receive a physician's care, must be reported to the Department. All incidents are investigated to determine measures that can be taken to prevent such occurrences in the future. (FY 09)	$57,000

IDPH	Manufactured Home Quality Assurance	Establishes standards for the installation of manufactured homes and licenses the installers and manufacturers of the homes.	Program ensures that manufactured home purchaser's in the State of Illinois receive a quality home and quality installation. Proposed new rules have been submitted to JCAR under 77 IAC 870. (FY 09)	$50,000
IDPH	Manufactured Housing	Reviews building plans for new models of modular dwelling and commercial mobile structures being located in Illinois to ensure that they meet safety standards.	The Department reviews plan documents to assure that modular dwellings and commercial mobile structures are in compliance with the adopted safety codes. (FY 09)	$50,000
IDPH	Physical Therapy/Speech Pathology Services	Conducts inspections and complaint investigations to determine compliance with federal certification requirements.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements (FY 08)	$41,300
IDPH	USDA Summer Food	Provides grants to local health departments (LHDs) to inspect summer food sites for underprivileged children.	1. The Summer Food Program makes federal funds available to IDPH to help assure the safe food preparation and service to underprivileged children at special feeding programs during the summer. 2. Illinois is the only state which passes this money through to local health departments by contracting for their inspection services of Summer Food Program feeding sites. 3. Existing organizations such as churches, community groups, schools and clubs who already have contact with underprivileged children are assisted in meeting the minimum requirements for the safe delivery of food. (FY 07)	$38,000

IDPH	Migrant Labor Camps/Field Sanitation	Reviews plans, issues permits and inspects and licenses migrant labor camps to ensure proper sanitation, adequate and safe water supply, proper sewage disposal, vector control, safety and sanitary food handling and field sanitation facilities. Investigates complaints at other agricultural operations that employ 10 or more agricultural workers to determine if the required toilets, drinking water and hand washing facilities are provided in the fields.	Migrant labor camps are inspected prior to occupancy and once during operation each year to assure that the water supply, sewage disposal systems and housing provide a safe and sanitary environment for the workers. The Department also reviews plans for any new migrant labor camp or the expansion of existing camps to assure that construction is in compliance with the code. The Department works closely with other state agencies and organizations that provide services to migrant workers and encourages them to report locations where migrant workers may be housed illegally and/or under dangerous or unsanitary conditions. (FY 09)	$25,000
IDPH	Safe Bottled Water	Requires a license from the Department to operate a water-bottling plant or a private water source in this State. The Department is to inspect bottling plants to ensure compliance with the Act and rules regarding the safe operation of those facilities.	1.) Maintained licensure system to collect business information on bottled water plants and water sources and issue permits. 2.) Provided information to regulated industry through mass mailing and industry groups. 3.) 41 in-state and 91 out-of-state and 34 out -of- country facilities have been licensed or registered. (FY 08)	$25,000

IDPH	Salvage Stores and Warehouses	Inspects, licenses and investigates complaints of salvage stores and warehouses where food, beverage, cosmetics, drugs and medical devices are handled.	1. Regulation of non-salvageable distressed food and other merchandise resulting from disasters, fires, accidents and other situations to prevent unwholesome products from entering commerce. 2. Not-for-profit salvagers such as the Food Depository, Second Harvest who donate/sell products to soup kitchens, charitable organizations and food pantries, are licensed and inspected (with no license fee), to protect the often highly susceptible recipients from receiving unwholesome food products. 3. Continuation of a cooperative agreement with the State Police regarding emergency food incidents based on the authority to regulate distressed goods. (FY 08)	$25,000
IDPH	Adult Blood Lead Registry	ABLR is one component of the Illinois Health and Hazardous Substances Registry. ABLR collects data on cases of elevated blood lead levels of 25 micrograms per deciliter and above for adults 16 years and older. Reporting level was changed to 10 micrograms per deciliter by NIOSH in October 2009. Cases are reported by laboratories. Reporting initiated in 1990.	About 71 percent of the laboratory reports are received electronically. ABLES reported 15 companies that had workers with lead levels more than 40 micrograms per deciliter, to OSHA. One site evaluation resulted in one citation for a serious violation and two citations for repeat violations with a proposed penalty of $14,700. OSHA continues to utilize these referrals to prioritize their inspection activities. (FY 09)	$20,400

IDPH	Health Maintenance Organizations	Establishes patient care standards and conducts tri-annual inspections and complaint investigations of HMO's.	Maintains files & reviews quality data submitted bi-annually & approves requested geographic svc area (FY 08)	$18,900
IDPH	Alternative Health Care Delivery - Regulation (Comm Based Residential Rehabilitation Center)	Establishes standards and conducts inspections to determine if community-based residential rehabilitative centers are an appropriate entity for healthcare delivery in Illinois.		$18,800
IDPH	Alternative Health Care Delivery - Regulation (Subacute Care)	Establishes standards and conducts inspections to determine if licensed Subacute Care programs are an appropriate entity for health care delivery in Illinois.	conducts inspections and complaint investigations (FY 08)	$18,800
IDPH	Alternative Health Care Delivery - Regulation (Children's Community-Based Health Care Center)	Establishes standards and conduct inspections to determine that the licensed facilities under the Demonstration Program for Children's Community-Based Health Care Center are in compliance with 77 Ill. Adm. Code 260 and deliver appropriate health care.	Conducts inspections and complaint investigations to determine compliance with state licensure requirements. (FY 08)	$18,700
IDPH	Alternative Health Care Delivery - Regulation (Post surgical Recovery Care)	Establishes standards and conducts inspections to determine if Post surgical Recovery Care Centers are an appropriate entity for health care delivery in Illinois.	Conducts inspections and complaint investigations to determine compliance with state requirements (FY 08)	$18,700
IDPH	Comprehensive Outpatient Rehabilitative Facilities	Conducts Medicare certification inspections and complaint investigations.	Conducts inspections and complaint investigations to determine compliance with federal requirements (FY 08)	$13,800
IDPH	Portable X-Ray Service	Conducts Medicare certification inspections.	Conducts inspections and complaint investigations to determine compliance with federal certification requirements (FY 08)	$13,800

Preparedness

IDPH	Laboratory Services	Provides laboratory testing for bacteria, viruses, parasites and environmental toxins which threaten the health of the citizens of Illinois; provides training and consultation for laboratories in hospitals, doctors' offices, and local health departments; and trains and certifies private milk testing laboratories and private water microbiology laboratories.	Laboratories rapid response in identifying the H1N1 SOIV New HIV and syphilis serology testing methods implemented. Implemented cystic fibrosis testing on all newborns born in Illinois. New Bio-safety level 3 laboratories brought on line in Carbondale and Chicago. (FY 09)	$22,357,500

Research

IDPH	Ticket For The Cure	The net revenue from the "Ticket For The Cure" special instant scratch-off lottery game shall be deposited into the Fund for appropriation by the General Assembly solely to the Department of Public Health for the purpose of making grants to public or private entities in Illinois for the purpose of funding research concerning breast cancer and for funding services for breast cancer victims. The Department must, before grants are awarded, provide copies of all grant applications to the Ticket For The Cure Board, receive and review the Board's recommendations and comments, and consult with the Board regarding the grants.	To date, the Illinois Lottery reports selling 2.15 million Ticket for the Cure scratch-off lottery tickets. The Ticket for the Cure Fund has received $6.58 in proceeds from the sale of the scratch-off lottery ticket. The Ticket for the Cure legislation requires a 10 member Board of which 8 are active, 1 is pending and 1 is vacant. (FY 09)	$5,500,000
IDPH	Lou Gehrig's Disease (ALS) Research Fund Grants	The Department of Public Health provides grants from the Lou Gehrig's Disease (ALS) Research Fund, a special fund in the State treasury, to the Les Turner ALS Foundation for research on Amyotrophic Lateral Sclerosis (ALS).	In 2007, a grant in the amount of $100,000 was provided to Les Turner ALS Foundation. (FY 07)	$1,100,000
IDPH	Penny Severns Breast, Cervical, and Ovarian Cancer Research Fund	Awards one year and multi-year grants to conduct research, trained inquiry or experimentation related to investigating causes, prevention and treatment; and awards fellowship grants to individuals with post doctoral training for the development of their research skills.	Since Fiscal Year 1995, 147 grants have been funded totaling more than $7.4 million with approximately $3.0 million contributed through the income tax check-off. (FY 09)	$900,000

IDPH	Epidemiologic Research	Conducts epidemiologic research using Registry data from all components of the Illinois Health and Hazardous Substances Registry. The purposes of the research unit are to: promote high quality research; address public concerns and questions about cancer, birth defects, and occupational injuries and fatalities including disease cluster investigations; respond to requests for available data; provide interpretation of data to more accurately target intervention resources for communities and patients and their families; and serve as a resource for IDPH programs concerning research and release of data.	Division staff continue to serve on the Department's Data Release and Research Committee, Committee on Public Use Files, Cervical Cancer Task Force, Illinois Data Dissemination Initiative, INEDSS Steering Committee and Illinois Violent Death Reporting System Advisory Committee (FY 09)	$423,400
IDPH	Spinal Cord Injury Paralysis Cure Research	Subject to appropriations, moneys in the Spinal Cord Injury Paralysis Cure Research Trust Fund shall be used to make grants to research facilities located in Illinois to conduct research to find a cure for spinal cord injury paralysis.	One grant for research to Institution for Spinal Cord Injury Paralysis Research. (FY 05)	$400,000
IDPH	Alzheimer's Disease Research Fund	The Illinois Department of Public Health (the Department) requests, receives and coordinates review of research grant applications focusing on the cause, progression, clinical care and cure of Alzheimer's disease and related disorders. Grant awards are possible through income tax check-off funds.	Five FY 09 Alzheimer's Disease Research Fund awards were granted to Southern Illinois University School of Medicine-Carbondale, the University of Illinois at Chicago, Rush University Medical Center, Loyola University-Chicago and Northwestern University. A total of 17 applications were received for FY 10 funding consideration. The Department conducted an internal review of each application, and found 14 were eligible for further review. A Peer Review Panel reviewed, scored and ranked the 14 applications and a summary of results was provided to the Alzheimer's Disease Advisory Committee. The Committee conducted the next review phase,	$350,000

			and scored and ranked each application. Final awards were based on the review results and available funding. (FY 09)	

Public Health Education

IDPH	Tobacco Free Communities	The Illinois Tobacco Free Communities grant program provides funding to all certified local health departments to implement tobacco programs within their communities. The goals of the program are: to eliminate exposure to secondhand smoke; promote quitting among adults and youth; prevent initiation among youth, and identify and eliminate disparities among specific populations. Programs implemented by the local health departments under this initiative are evidence-based and community designed to meet the needs of the local jurisdictions. The model programs offered are based on the Centers for Disease Control and Prevention "Best Practices for Comprehensive Tobacco Control Programs" (Oct. 2007). These best practices coincide with the CDC National Tobacco Control Program Goal Areas and Healthy People 2010 objectives. Numerous local health departments have identified tobacco prevention and control in their Illinois Project for Local Assessment of Needs (IPLAN) as priority health areas. Other model programs using proven intervention strategies developed by the American Lung Association, American Cancer Society, and the American Heart Association are also utilized and are considered effective. All programs are evaluated regularly to assure their efficacy.	Passage of the Smoke-Free Illinois Act has greatly assisted the ITFC program in making progress in the elimination of tobacco smoke in public places. The Illinois Tobacco Quitline contractually operated by the American Lung Association of the Upper Midwest has increased staff to 20 to offer cessation services to those wanting to quit. Break the Habit -- a nicotine replacement therapy program expanded to approximately 40 local health departments. ITFC staff collaborated with the Office of Women's Health to offer cessation referrals through the Wisewoman and Illinois Breast and Cervical Cancer Program. (FY 09)	$10,062,000

IDPH	Illinois HIV/AIDS Communities of Color Initiative	The Center for Minority Health Services provides grants for outreach, awareness, prevention, education and testing programs with the main focus being HIV/AIDS within communities of color.	Over 60 grantees funded through the Center for Minority Health's Communities of Color Initiative have impacted over 273,000 individuals with outreach, awareness, prevention, and education activities; over 6,944 HIV tests were administered, over 387 referrals for treatment, and media outlets with circulation totaling 5,500,000 provided service advertisements regarding the initiative. (FY 08)	$5,055,000
IDPH	Illinois Breast and Cervical Cancer Communities of Color Initiative	The Center for Minority Health Services provides grants for outreach, awareness, prevention, referral, screening, and education programs with the main focus being Breast and Cervical Cancer within communities of color.	During fiscal year 2008, the Department's Center for Minority Health Services' Illinois Communities of Color Breast and Cervical Cancer Initiative provided women with more than 17,627 screenings, reached more than 131,323 women with educational information, and publications with circulation totaling 4,500,000 provided public service advertisements regarding the initiative to their readers. (FY 08)	$4,000,000
IDPH	Sexually Transmitted Diseases	Promotes the prevention and containment of sexually transmitted diseases (STD) and their resultant complications; coordinates statewide surveillance, outbreak response, sex partner notification, referral, testing, treatment and counseling; coordinates a comprehensive screening program to identify and treat persons infected with Chlamydia and gonorrhea; coordinates syphilis elimination activities; procures and distributes antibiotics, condoms, and educational materials to health care providers serving high risk clients; coordinates HIV testing in STD clinics; and coordinates the integration of adult viral hepatitis	Processed STD laboratory reports from private and commercial laboratories for 807,089 gonorrhea tests, 797,592 Chlamydia tests and 1,508,973 syphilis tests. Coordinated a comprehensive STD-related infertility prevention program that conducted 170,769 combined, nucleic acid-amplified, Chlamydia and gonorrhea tests resulting in the identification and treatment of approximately 15,389 persons	$2,716,300

		prevention services into existing STD, HIV and drug treatment programs.	infected with Chlamydia and 6,052 persons with gonorrhea. Conducted 67,792 screening tests for syphilis resulting in the identification of 3,990 persons requiring evaluation for treatment. Screened 24,311 STD clinic clients for HIV resulting in the identification of 197 infected persons (0.8 percent positive). Collaborated with the IDPH HIV Program in conducting a statewide HIV/STD conference for over 600 health care professionals and persons infected with or affected by HIV/AIDS and other STDs. Provided STD training utilizing the Internet to health care providers resulting in significant travel-related cost savings for providers and IDPH staff. (FY 09)	
IDPH	Brothers and Sisters United Against HIV/AIDS (BASUAH)	A comprehensive HIV/AIDS Awareness Campaign targeting the African American community to address the health disparity the African American population experiences with regard to HIV/AIDS. The awareness campaign focuses on prevention programs, awareness, education, and testing.	During Fiscal Year 2008 over 5,000,000 individuals were impacted by the BASUAH Project throughout Illinois, including conferences, health fairs, 319,360 outreach and education, and 5,500,000 media circulation; and 2,562 individuals tested for HIV. (FY 08)	$1,994,000

IDPH	Women's Health Promotional Services	Provides information and technical assistance regarding women's health needs; promotes awareness of specific disease and conditions that affect women; recommends treatment methods and programs; and awards grants to LHD and community based organizations that address osteoporosis, healthy behavior modification, cardiovascular health, and menopause.	FY 09 accomplishments include: 1) 12,000 women participated in educational sessions made possible through grant programs. 2) Brochures and newsletters were printed in English and Spanish and were included on the Illinois Department of Public Health website. 3) The Annual Women's Health Conference was held in November 2008 with more than 375 professionals in the field of health and medicine. 4) Health education trainings and events were held to highlight cardiovascular disease and breast and cervical cancer. (FY 09)	$1,367,000

IDPH	Asthma Program	In response to Illinois Senate Bill 81, Public Act 91-0515, the Illinois Department of Public Health created the Illinois Asthma Task Force that developed the "Addressing Asthma in Illinois" plan in 1999. A second revision to the plan was completed for 2007 and a third revision was completed in 2009. The Illinois Asthma Program, established in 1999, is funded by the U.S. Centers for Disease Control and Prevention (CDC) to build capacity, infrastructure and implement interventions to address the asthma state plan. Six priority areas are addressed within the asthma state plan: 1) advocacy and policy; 2) data, assessment and outcomes; 3) education; 4) occupational asthma; 5) schools; and 6) sustainability. The Asthma Program created the Illinois Asthma Partnership (IAP) in 1999 as an expansion of the Asthma Task Force. The IAP has grown to over 150 members over the last ten years. Within the IAP, five work groups have been active to meet the goals and objectives in the asthma state plan, specific to their focus area. The five Work Groups include: advocacy and policy; data, assessment and outcomes; education; occupational asthma and schools. An Executive Committee functions as the leadership for the IAP. The Executive Committee consists of the chair and co-chairs of the Work Groups, two members at large, and representatives for the local asthma coalitions. Local asthma coalitions were formed in 1999 as a result of funding from the Asthma Program. Over the course of the Asthma Program, additional asthma coalitions have been developed. The local asthma coalitions and the IAP assist the Asthma Program with implementing interventions to address the goals and objectives of the asthma state plan.	Three regional asthma coalitions and six local asthma coalitions were funded to implement interventions to address the asthma state plan goals and objectives. All asthma coalitions are required to work on one common intervention and in FY 09, addressing asthma in disparate populations was selected. A new partnership was developed with the Girl Scouts of Central Illinois to implement asthma education in their Girl Scout camps for girls to earn an asthma merit patch. The Asthma Program continues its project with Rush University to implement a Web-based asthma surveillance system in the emergency department setting. Two local health departments (Cass and Kane) and the Southern Illinois University Health Education Program were selected to address asthma in the Hispanic/Latino populations. The Respiratory Health Association Metro-Chicago will be implementing an asthma project in the community of Englewood. This project will work with the community pharmacies and local providers to distribute asthma education to parents of children with asthma with the outcome to have asthma action plans on file at schools for children with asthma. (FY 09)	$885,000

IDPH	Hepatitis C Education and Outreach	Subject to appropriation, the Department shall conduct an education and outreach campaign, in addition to its overall effort to prevent infectious disease in Illinois, in order to raise awareness about and promote prevention of Hepatitis C. Subject to appropriation, in addition to the education and outreach campaign, the Department shall develop and make available to physicians, other health care providers, members of the armed services, and other persons subject to an increased risk of contracting Hepatitis, educational materials, in written and electronic forms, on the diagnosis, treatment, and prevention of the disease. These materials shall include the recommendations of the federal Centers for Disease Control and Prevention and any other persons or entities determined by the Department to have particular expertise on Hepatitis, including the American Liver Foundation. These materials shall be written in terms that are understandable by members of the general public.	Hepatitis C continues to demand attention in Illinois as hospital discharge data from 2000-2006 showed an increase from 7,274 hospitalizations in 2000 to 15,244 hospitalizations due to hepatitis C infections in 2006. Over 3,000 new cases of chronic hepatitis C are identified annually. During FY 07, DID staff have collaborated to expand education and outreach efforts to address hepatitis C infection within IL. Staff have: Established an Adult Viral Hepatitis Prevention Coordinator to coordinate the IDPH Division of Infectious Diseases Viral Hepatitis Collaboration and Services Integration Workgroup consisting of key staff in the Communicable Diseases, HIV/AIDS, Immunization, Perinatal Hepatitis B, STD, INEDSS and Tuberculosis Programs who are working to integrate viral hepatitis prevention services into training programming and clinic services. Developed a surveillance module within INEDSS to allow electronic reporting of hepatitis C by providers and laboratories to expedite case investigation and management by local health department authorities. In conjunction with case reporting and management, the Department, in accordance with CDC recommendations, routinely	$460,000

			provides local health departments with hepatitis A and B vaccines for uninsured persons with hepatitis C infection. Collaborated with the Chicago Department of Public Health, Illinois Department of Human Service Division of Alcohol and Substance Abuse, and the Midwest AIDS Training and Education Center to develop and perform six Comprehensive Viral Hepatitis Training programs across the state at which 245 participants were trained from the following settings: STD, HIV, Drug Treatment, community based organizations, family planning, drug treatment, corrections, infectious disease primary care clinics, university and pharmacy care. Continued to screen all self-reported IDUs attending downstate STD clinics for hepatitis C infection, identifying over 100 new cases (about 15 percent of clients tested) during FY 07; over 70 percent who have started preventive vaccination against hepatitis A and B. Collaborated with the IDPH HIV Care Section to ensure availability of hepatitis A and B vaccination of Title II HIV Care clients, particularly those co-infected with hepatitis C. Collaborated with the IL Chapter	

			of the American Liver Foundation and the Chicago Department of Public Health to participate in a Legislative Forum on hepatitis C in Springfield in May 2007. Completed the Viral Hepatitis Strategic Plan for IL, which is awaiting publication and distribution in 2008. (FY 07)	
IDPH	Sudden Infant Death Syndrome (SIDS)	Provides information and counseling services to families who experience the sudden, unexpected death of an infant under the age of one year.	The Statewide SIDS Program operates through a networking system. When an infant dies suddenly and unexpectedly, the coroner/medical examiner notifies Program staff. A trained SIDS counselor (public health nurse) provides counseling and support to all families in the state who experience the sudden and unexpected death of their infant. Seminars and workshops sponsored by the Program are held to inform health care providers, coroners, pathologists, public health nurses and families about current issues regarding this area of infant mortality. (FY 07)	$350,000
DHS-CHP	Diabetes Prevention and Control	Lesson the burden of diabetes through prevention and intervention activities in partnership	Reduce Chronic Conditions	$335,300

IDPH	Prostate and Testicular Cancer	The Department, subject to appropriation or other available funding, shall conduct a program to promote the awareness and early detection of prostate and testicular cancer. Beginning July 1, 2004, the program includes the development and dissemination, through print and broadcast media, of public service announcements that publicize the importance of prostate cancer screening for men over age 40.	Formed partnerships with other state agencies and related organizations to advance this program, including actively participating in public events throughout the state at state fairs, public events, conferences, and awareness days that resulted in the additional screening of Illinois men for prostate cancer. The fourth annual report was completed and put forward for release to the General Assembly. (FY 09)	$290,000
IDPH	Craniofacial Anomaly	Provides educational and referral information to families of infants born in Illinois with cleft lip or cleft palate; and promotes efforts to improve the identification, reporting and early intervention in the lives of children with craniofacial anomalies.	Illinois has the first reporting and referral program for craniofacial anomalies in the United States. We conducted the surveys that were used as the basis for the addition of an oral health objective to Healthy People 2010 regarding craniofacial anomalies which our program meets. In 1990, this program received the United States Department of Health and Human Services' Outstanding Health Promotion Award. In FY 08, the program staff met with community programs to expand the education outreach materials to both community level home nurse visitors and the Illinois Perinatal Network for birth center distribution. The expansion will begin in FY 09 in southern Illinois as a pilot phase. Program coordinator meets with professional groups in Illinois to share data and resources for	$111,000

			Illinois families. (FY 08)	
IDPH	Women's Health-Line	A toll-free number providing information and referrals related to women's health programs, services and resources.	In FY 09 the Women's Health Line hired a full time Spanish Speaking staff member assist Spanish Speaking callers. The Illinois Breast and Cervical Cancer Program expanded to eliminate the income requirement for eligible women. To assist with efforts to reach the newly eligible women 11 new Lead Agencies were added. The Women's Health Line has added the new Lead Agencies to their referral network and has served as a gateway for women to enroll in the screening program. (FY 09)	$86,400

IDPH	Minority Health Development	Provides information and technical assistance regarding the health care needs of minority populations, and develops, maintains and enhances health care services within communities of color.	The Center for Minority Health Services provided grants to two community based organizations through the Minority AIDS Drug Assistance Program (ADAP) to provide outreach and education regarding ADAP and provide linkages to care and treatment services for HIV positive individuals. (FY 08)	$78,000
IDPH	Consumer-oriented Patient Safety Reporting	Implements the Hospital Report Card Act and legislation creating the Consumer Guide to Health Care. Convenes the Facilities Report Card Advisory Committee and subcommittees to participate in advising the Department on implementation.	* Vendor chosen for data collection and management and to put up web site for data display * Hospitals not exempt from CLABSI reporting requirement enrolled in NHSN, joined and conferred rights to the State group, and began using NHSN to report CLABSI data in January 2009 (FY 09)	$70,489
IDPH	Donated Dental Services/Dental House calls	Refers indigent elderly and disabled residents to dentists -- who volunteer their services -- and provides a mobile dental office to enable dentists in Chicago to treat disabled and elderly people unable to travel to dentists' offices.	In FY 08, the Donated Dental Services Program reached another huge milestone: more than $8 million worth of free dental treatment has been donated to 4,109 disabled and aged people in Illinois since the program began in 1990. Thanks to 768 generous dentists and 181 dental laboratories that volunteer, these individuals were given the gift of good oral health that they could not have otherwise received. This year was the first ever in which more than $1 million worth of services were donated. (FY 08)	$69,800

IDPH	Colon Cancer Awareness Campaign	The Department must establish and maintain a public awareness campaign to target areas in Illinois with high colon cancer mortality rates. The campaign must be developed in conjunction with recommendations made by the American Cancer Society. The Vince Demuzio Memorial Colon Cancer Fund income tax check off was created to provide funding for the campaign.		$56,400

REHABILITATIVE / HABILITATIVE SERVICES

Overview

Illinois funds and oversees an array of programs that provide home and community-based supports that allow people of all ages with disabilities or special health care needs to live, learn and work in their communities, and that provide institutional care to those who are severely disabled.

The Illinois Human Rights Act (HRA) defines disability as "a determinable physical or mental characteristic of a person, including, but not limited to, a determinable physical characteristic which necessitates the person's use of a guide, hearing or support dog, the history of such characteristic, or the perception of such characteristic by the person complained against, which may result from disease, injury, congenital condition of birth or functional disorder […]."[1]

Intellectual disabilities or developmental disabilities include mental retardation and related conditions. These are a distinct type of disability that, according to the Illinois Council on Developmental Disabilities:

- Are attributable to a mental or physical impairment or combination of mental and physical impairments.
- Are manifested before the person reaches age 22.
- Are likely to continue indefinitely.
- Result in substantial functional limitations in three or more areas of major life activity, such as self care, learning, or capacity for independent living.
- Reflect the individuals need for services, individual supports, or other forms of assistance.[2]

Human services for people with disabilities reflect a core, moral value of our society. They affirm that each member of our community has something to contribute and the right to function at their maximum capacity.

Our laws also reflect this belief. The Americans with Disabilities Act (ADA) of 1990 literally transformed our nation's built environment, transportation systems, technological infrastructure and employment practices. While ADA's broad swath focused primarily on the public square, nine years after its passage, the Supreme Court affirmed that these values extend to living arrangements as well. The court's 1999 *Olmstead v. L.C.* decision established that: "Community placement is required when the state's treatment professionals determine community placement is appropriate, the individual, or his/her guardian, does not oppose transfer from institutional care, and placement can be reasonably accommodated by the State taking into account the resources available, and the needs of others with

[1] http://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=077500050HArt percent2E+1&ActID=2266&ChapAct=775 percentA0ILCS percentA05 percent2F&ChapterID=64&ChapterName=HUMAN+RIGHTS&SectionID=64484&SeqStart=100000&SeqEnd=600000&ActName=Illinois+Human+Rights+Act percent2E

[2] State of Illinois Council on Developmental Disabilities, http://www.state.il.us/agency/icdd/faq/faq.htm. For the federal definition of developmental disabilities, please see http://williamshaffer.org/dd-def/developmental-disabilities-def.htm

mental disabilities."[3] The HRA is one of several state laws that further protect people with disabilities. Others include the Environmental Barriers Act and the Illinois Accessibility Code.[4]

This section of the report focuses on Department of Human Services (DHS) programs in two divisions – the Division of Developmental Disabilities (DDD) and the Division of Rehabilitation Services (DRS). According to data provided by DHS, FY 10 funding for these programs totaled just over $2.06 billion. There are dozens of programs in these areas; this discussion is necessarily selective. It should also be noted that people with disabilities receive services from other state departments and divisions, including the DHS's Division of Mental Health (DMH), the Illinois State Board of Education (ISBE) and the Illinois Department of Aging (DOA). Many of these programs are discussed in other sections of this report.

Populations Served

As noted above, disability is a broad category, one that encompasses a range of physical and intellectual development conditions.[5] The following citations are from a recent study commissioned by Health and Disability Advocates:[6]

- Just over half a million people (566,470) in Illinois ages 15 to 64 report having a disability.[7]

- In terms of race/ethnicity, the disabled population is 63 percent white, 24 percent African American, 10 percent Latino and three percent other. The non-disabled population is 67 percent white, 14 percent African American, 13 percent Latino and six percent other. Although African Americans are overrepresented among people with disabilities, in numerical terms, the number of white people with disabilities (354,059) is over twice the number of African Americans with disabilities (135,900).

- People with disabilities are more likely to be in poverty than the non-disabled population. Over one quarter (28 percent) of people with disabilities are below 100 percent the federal poverty level (FPL) compared with nine percent of non-disabled population.[8]

- Almost one in five (19 percent) people with disabilities (108,000) in Illinois do not have health coverage.

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[3] Olmstead v. L.C. at 119 S. Ct. at 2181 (1999)

[4] http://www.illinoisattorneygeneral.gov/rights/disabil_rights_factsheet0209e.pdf. For more information on legislation impacting services provided to people with disabilities, see Appendix F: Historical Milestones in the Development of Human Services.

[5] This report focuses on services to individuals with disabilities covered by state programs. It should be noted that there are several other types of disabilities that are not currently funded through Illinois statutes, such as Asperser's Disorder and fetal alcohol spectrum disorders.

[6] *A Snapshot of People with Disabilities in Illinois*, prepared by Rob Paral and Associates. Available at *www.hdadvocates.org/library/file.asp?id=300634*

[7] This is a conservative estimate of the number of people with disabilities in Illinois, because the question in the Current Population Survey is specifically about disability-related work limitations. For other disability estimates and definitions, please see: www.disabilitystatistics.org.

[8] The FPL in 2007 was $10,210 per one person family or household.

- Just over one-quarter (28 percent) of people with disabilities have only private health insurance compared with 75 percent of the non-disabled population ages 15 to 64) who have only private health insurance.

- People with disabilities without health insurance are disproportionately low income compared to the non-disabled uninsured population. Just under half (42 percent or 45,000) of people with disabilities without health coverage are below 100 percent FPL, compared with 26 percent of non-disabled, uninsured population who are below 100 percent FPL.

In order to access services, people with disabilities must meet specific medical disability-related eligibility criteria. To become eligible for home services, typically applicants for DRS rehabilitation services must also meet a specific score on a Determination of Need scale in order to prove they are at risk of institutionalization. There are also various eligibility criteria for income, assets and citizenship / immigration status that differ with each program.

It should be noted that some people who need services do not seek them because they find the eligibility and enrollment process too complicated and / or hard to access and understand. Others apply and are put on waiting lists. There is, therefore, a hard-to-quantify gap between who is or would be eligible and who is served. Some data are available through DHS Prioritization of Urgency of Need Reports, the most recent of which (April 2010), counts 19,662 unduplicated individuals with development disabilities who are in need of a range of services.

The number of individuals receiving disability services is growing: Over 16,500 adults and children with developmental disabilities are receiving services under three Medicaid Home and Community-Based Services (HCBS) waivers (described below). The number of waiver participants has doubled in the last seven years. In addition to the waivers, according to DHS-DDD approximately 25,000 children and adults will receive other state-funded disability services during FY 10. Additionally, approximately 33,000 people are expected to receive home services through DHS-DRS in FY 10.

Service Delivery System

The rehabilitative and habilitative services system in Illinois is large and complex, involving hundreds of contracted providers and sites. For example, DHS-DDD contracts with 412 private provider organizations that serve individuals with developmental disabilities. DHS-DRS's Home Services Program employs over 25,000 individuals as personal assistants who work directly for the person receiving service and are not employed by a community agency. Eighteen independent service coordination agencies around the state contracted by DHS-DDD take applications for services and determine eligibility for programs. This figure also includes private Intermediate Care Facilities for persons with developmental disabilities (ICFs/DD) as well as a variety of day programs for adults, residential group homes and home-based services. In addition, DHS-DDD operates eight Developmental Centers. DHS-DRS has 48 local offices throughout the state providing a range of services and contracts with hundreds of provider agencies.

The state provides HCBS through Medicaid waivers that provide services that allow individuals to remain in their own home or live in a community setting.[9] To participate in Medicaid HCBS waivers, individuals must qualify for Medicaid benefits and meet financial eligibility requirements. While the Department of Healthcare and Family Services (DHFS) manages the state's Medicaid program, DHS divisions, including DDD and DRS, operate the HCBS waivers, meaning that they make eligibility and enrollment determinations and manage contracts and providers.

DHS-DDD operates three waivers that provide services for adults and children with developmental disabilities. These provide a range of services, from home and vehicle modifications to skilled nursing care. In some instances waivers can be used for intermittent residential habilitation in settings such as Community Integrated Living Arrangements (CILAs). DHS-DRS operates three other HCBS waivers, for persons with disabilities, persons with HIV/AIDS, and persons with brain injuries. The specific types of services provided through each waiver varies but include an array of services that help people to live as independently as possible, such as homemakers to assist with housework and adult day care.

In general, home and community based services are most frequently delivered by nonprofit and for-profit providers under contract to DHS divisions. Through HCBS waivers, eligible families can hire personal assistants and homemakers to help care for the disabled family member (in some cases, a family member who cares for the individual is contracted to provide this support). Through DDD's three HCBS waivers alone, more than 4,000 personal support workers are employed by families to help support family members with developmental disabilities. Facility-based services (State Operated Developmental Centers, or SODCs, and ICF/DDs) are operated by either nonprofit or for-profit entities, or by the state itself, which owns and administers some facilities and their services.

In sum, the service delivery system for people with disabilities includes the following components:

RESIDENTIAL SUPPORTS

These programs include 24-hour care in a variety of settings. Most settings are home-like and integrated into the community, where individuals have access to on-site direct support staff as needed.

- CILAs: Group homes in the community that serve up to eight adults with developmental disabilities or mental illness and are licensed by DHS.

- ICF/DDs: Homes of varying size, from small group homes to hundreds of residents, which are licensed by the Department of Public Health. Smaller homes are often located on campus-style settings.

- Child Group Homes and Child Care Institutions: Residential settings for children with developmental disabilities, licensed by the Department of Children and Family Services (DCFS).

- SODCs: Facilities operated by the state that provide services for individuals with developmental disabilities who have severe medical and/or behavioral needs.

[9] For more information on HCBS waivers, see http://www.hfs.illinois.gov/hcbswaivers/.

Another type of residential support is Institutes of Mental Disease (IMD), primarily for people with severe and persistent mental illness. These are operated by DHS's Division of Mental Health and covered in the Mental Health section of this report.

HOME AND COMMUNITY BASED SERVICES (HCBS)

As noted above, the main way that people access HCBS is through Medicaid waivers, including three waivers for children and adults with developmental disabilities operated through DHS-DDD and three for people with physical disabilities, brain injuries or HIV/AIDS operated through DHS-DRS. The services available through each waiver vary, but the range of services includes:

- Personal care assistant services
- Homemaker services
- Home-delivered meals
- Skilled nursing
- Physical, occupational and speech therapies
- Specialized medical equipment and supplies
- Adult day care
- Personal emergency response systems
- Assistive technology and adaptive equipment
- Vocational supports such as job coaching and on the job supports
- Training and counseling services for unpaid caregivers

DAY SUPPORTS

- Day Programs: Daily activities provided at a center ranging from workshops to arts programs to community day trips
- Employment Programs and Vocational Rehabilitation: DHS-DRS provides a broad range of employment services for people with disabilities, including Vocational Rehabilitation and Supported Employment. These services are covered in the Employment section of this report.

The system is designed to identify and respond to a continuum of need, so that higher-need participants receive more intensive services. The 1999 Olmstead Supreme Court decision further mandates that people with disabilities be served in the least restrictive setting appropriate to their needs.

One important factor related to ICF-DD services as compared to CILA or HCBS is the fact that ICF-DD services are an entitlement that only requires a willing provider and available bed. This is an important distinction; an entitlement program is a program that an individual who meets both the means test and disability criteria is "entitled" to access. A waiver program allows the state to target the service to certain populations, modify the income and asset tests and provide services and supports not available as an entitlement, so the state can cap or limit access to the services. Illinois, in fact, does limit access to the number of people with developmental disabilities served in CILA and HCBS waiver programs based on funding levels approved by the General Assembly.

Funding

According to FY 10 data provided by DHS, rehabilitative and habilitative services, including services for people with physical and intellectual disabilities, were budgeted in FY 10 at a total of $2,058,493,793.[10] This figure does not include Vocational Rehabilitation and other employment services provided through DRS. The bulk of funding is for HCBS waivers through DRS and DDD, ICF/DDs, CILAs, state-operated developmental centers, day programs for people with developmental disabilities and disability determination services at DRS. Some of the smaller programs included in the budget are schools for the deaf and visually impaired operated through DRS, DRS centers for rehabilitation and education for people with significant physical disabilities and other residential and community-based services.

A number of factors affect the funding picture for this part of the human services system, including the following:

- A historic pattern of low rates for the service system for individuals with disabilities, without regular Cost of Doing Business (CODB) increases. As of this writing, this includes a proposed 2.5 percent rate decrease in Governor Quinn's FY 11 budget for developmental disability service providers

- A budget and appropriation process that creates segregated budgets in the long-term care system, making it difficult to move resources from institutions into home and community based settings, or vice versa.

- The balance between providing care for people with disabilities in community settings and institutions has implications for costs and funding. Some studies show that serving people with disabilities – including those with more intensive needs – in their homes and communities, as opposed to in an institutional setting, is less expensive for the state.[11] Licensing requirements differ among the various types of institutions and programs, which affects funding and revenues.

  One reason for this is the workers in community-based agencies are usually paid significantly less than the state workforce. According to DHS-DDD, the average cost to serve an individual in a SODC is approximately twice the cost of serving an individual in a private ICF-DD. The average cost of serving adults in licensed CILA 24-hour group homes is comparable with private ICF-DD costs. Per DDD, home-based services cost on average about one-third of the cost of 24-hour residential support in either a CILA group home or a private ICF-DD. It should be noted that the cost of care in an SODC includes medical services while the cost figures for the other settings do not, and the intensity of need for services varies by setting, which also affects cost. Some studies have found that there are few savings when taking into account client needs and the type and hours of care provided.[12]

[10] While DHS and its contractors provide services, much of the funding comes through Medicaid, which is discussed in the "Health Care and Support" section of this report.

[11] See *Report of the Taxpayer Action Board*, June 2009, page 21. Available at: http://www.illinois.gov/PressReleases/Documents/TAB percent20Report percent20FINAL.pdf

[12] Walsh, K., Kastner, T., & Gentlesk Green, R. (2003). Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research. Mental Retardation, volume 41, pp. 103–122.

- Under the new Patient Protection and Access to Care Act (PPACA, or health care reform), states will be under the Maintenance of Effort (MOE) requirement that was put in place under ARRA (stimulus funding) in 2009. This means the state of Illinois cannot restrict eligibility to any Medicaid funded program that was in place as of July 2008 without facing a reduction in enhanced federal matching percentage (FMAP) available to the state until June 30, 2011. In Illinois that enhanced FMAP is 66 percent versus Illinois' regular 50-50 match. While enhanced FMAP for states is scheduled to end on June 30, 2011, states will still be under the MOE requirement until December 31, 2013. Therefore, any proposed cuts to HCBS will affect Illinois' FMAP, pending further clarification from the Centers for Medicare and Medicaid Services.

Various Medicaid court decisions and federal statutes and regulations mandate what federal funding can and should be used for in the provision of rehabilitative and habilitative services in the states. The state is currently in the process of coming to an agreement in three court cases involving people with disabilities and the system for providing home and community based services for them. One case, *Ligas et al*, is a class action lawsuit filed in 2005 to redress violations of the Americans with Disabilities Act for individuals with developmental disabilities. A consent decree has been proposed that would "assist the Division [DHS-DDD] in expanding its community-based system to meet the growing demand for those services, while continuing to honor an individual's choice in deciding on the types of services and settings he or she prefers in order to live a personally fulfilling and productive life."[13]

Historical data compiled by the ARC of Illinois and shared with the Human Services Commission is summarized in the chart below. The data tracks the changes in funding appropriations over the last ten years for SODCs and community funded programs that provide care for people with developmental disabilities.

In the chart, the green "SODC" line refers to State Operated Development Centers. The red "community" line refers to community supported programs such as group homes, home-based supports, day training and employment supports. The blue "CPI" line refers to the Consumer Price Index.[14]

The chart illustrates that the amount of funding appropriations in the final state budget for SODCs has increased by 45 percent, while funding appropriations in the final state budget for community programs has increased by 12.5 percent. During the same time period, the CPI rose 30.8 percent. Using CPI as a comparison, the data show that SODC appropriations have increased at a rate higher than the CPI while appropriations to community supported programs have trailed the CPI.

According to Braddock and Hemp in the *Services and Funding For People With Developmental Disabilities in Illinois: A Multi-State Comparative Analysis*, 2008,[15] Illinois committed less funding for community based services in 2006, in inflation adjusted terms, than it did in 2002. While the census has declined in the state-operated facilities, the utilization rate is more than 60 percent above the national

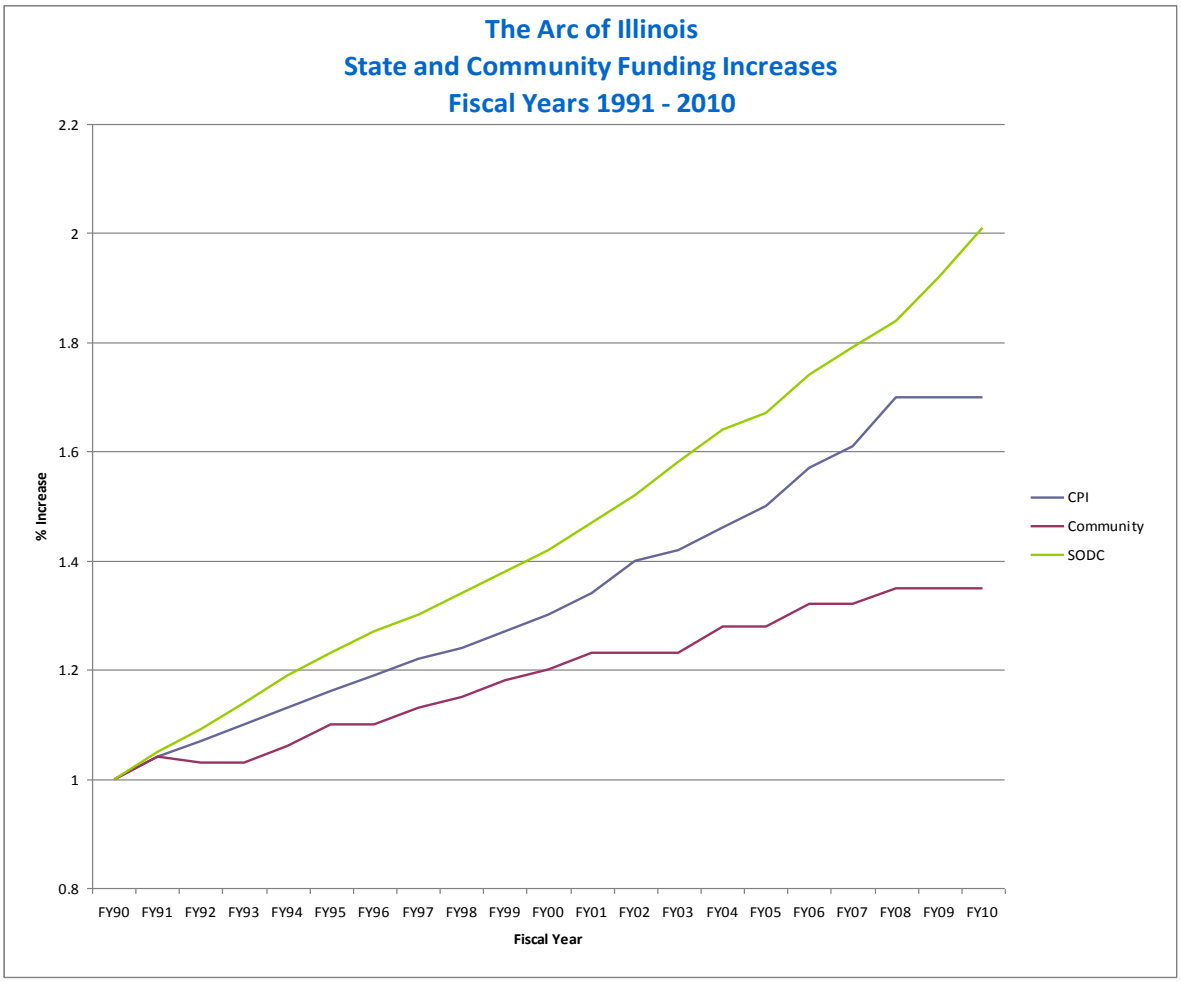
[13] DHS Ligas Lawsuit web page, http://www.dhs.state.il.us/page.aspx?item=40989

[14] The Consumer Price Index is a standard measure used to estimate the average price of consumer goods and services purchased by households. It is used as a point of comparison to show that where funds to support the state-operated developmental centers serving 2,000 people, as well as funds to support over 45,000 people in community settings, fall.

[15] David Braddock, Richard Hemp, Mary C. Rizzolo, *The State of the States in Developmental Disabilities*, (Washington, DC: American Association on Intellectual and Developmental Disabilities, 2008), page 18, table 4.

average in the United States. Only 30 percent of individuals living in Illinois are housed in six person or fewer community based group homes as compared to 70 percent in the rest of the United States.

According to the same study, Illinois' utilization of institutions, consisting of state institutions and private facilities for 16 or more persons including nursing facilities, was on average 63 per 100,000 of the general population. This figure is nearly double the average for the entire United States which is 34 per 100,000. Illinois ranked 6th nationally in public/private institutional utilization; only five states Arkansas, Iowa, Louisiana, Mississippi and Oklahoma had higher utilization rates. Illinois public/private utilization rate for institutions exceeded the trend for the entire United States and all five comparison states reviewed in the study (Indiana, Michigan, Minnesota, Ohio and Wisconsin). The study further notes that Illinois supports 2,709 individuals with intellectual/developmental disabilities in state-operated institutions. There are an additional 3,737 individuals in approximately 65 privately operated institutions throughout the state. These private institutions in some cases house more than 250 individuals. In 2006, Illinois' utilization rate for private 16-person or more institutions, not including nursing homes was 29 per 100,000. It should be noted that this rate is nearly three times the national average and only two states -- Iowa and Oklahoma -- had higher rates of placement than Illinois for individuals with intellectual/developmental disabilities placed in private institutions with 16 or more people.



Critical Issues and Trends

Providing direct support to people with disabilities is physically and emotionally demanding work. Many workers employed by state-funded community agencies earn wages well below the poverty line for a family of four and are offered little in the way of health insurance and retirement benefits. As a result, the turnover rate in this field is 43 percent.

High turnover, along with difficulty in filling job positions, affects quality of care. A University of Illinois / University of Minnesota study found that Illinois direct support workers' hourly wages increased an average of 34 cents from 2003 to 2008, or about 3.6 percent over five years. During the same period, the Social Security Administration provided cost of living increases of 14.5 percent. The study found that "without significant changes in how direct support staff are paid, it will be difficult to maintain (let alone grow) a community direct support workforce."[16]

In 2008, Illinois ranked 51st out of the 50 states and the District of Columbia in the number of people with developmental disabilities in an out-of-home residential setting who reside in settings for one to six people (such as CILAs).[17] Today, more than 10 years after the Olmstead decision, the use of home and community-based services versus institutional care remains a critical issue in the field, particularly for individuals with developmental disabilities. It is sometimes assumed that home-based care takes place in an individual's family home; however, there are a range of community-based residential options for people with developmental disabilities, including CILAs and other congregate living options. Home and community-based services and institutional care have their place in the continuum of care for people with developmental disabilities. Finding the right balance between these options is an enduring issue.

Age-related transitions are another key issue. Eligibility, services and delivery systems vary by age group, so as people with disabilities age out of children and adult programs – in particular children who are medically fragile and technology dependent – and into those that serve adults or older adults, it creates challenges, especially when programs administered and budgeted in different agencies and divisions. In some cases, people who age out of programs do not regain entry into others.

The aging of the caregiver population is another critical trend, in light of Baby Boomer generation demographics. A number of individuals are living with and being taken care of by aging caregivers. When those caregivers experience an illness episode, it can create an emergency situation. The current continuum of services and supports (24-hour, intermittent and home based) has not always reflected the need for short-term care related to a caregiver's illness episode.[18]

[16] Final Report of the Illinois Direct Support Professional Workforce Initiative, conducted by the Institute on Disability and Human Development (University of Illinois), and the University of Minnesota.

[17] *The State of the States in Developmental Disabilities 2008*, David Braddock, Richard Hemp, Mary C. Rizzolo, 2008, page 18, Table 4.

[18] The home-based services program for adults with developmental disabilities includes a relatively new crisis / temporary assistance service that is able to respond with increased supports for up to 60 days.

Human Service Category: Rehabilitative/Habilitative Services

Data Source: State agencies as indicated in the first column

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DHS-DRS	Home Services Program	The Home Services Program (HSP) offers individuals with disabilities who are at risk of premature or unnecessary institutionalization the alternative of in-home care when the cost of home care does not exceed the cost of a nursing facility. The program operates three waivers, Persons with Disabilities, the AIDS, and the Brain Injury Waiver. The HSP promotes independence by offering an individualized approach for individuals with the most significant disabilities, allowing them to stay in their homes, be involved in their communities and retain control over the services they receive.	Provides an array of services designed to prevent unnecessary nursing facility placement. These services include PA services, homemaker services, maintenance home health, electronic home response, day care, assistive equipment, and respite care.	$532,727,870
DHS-DDD	ICFDD (Residential only)	Residential		$327,547,300
DHS-DDD	CILA - Model Rate (res only)	Residential		$312,201,300
DHS-DDD	State-Operated Dev Ctr	Residential		$291,903,700
DHS-DDD	Day FFS Programs	Active Treatment		$127,167,400
DHS-DRS	Disability Determination Services	Determines the eligibility of people to receive benefits under Social Security's disability programs, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).	An individual's eligibility for disability benefits is based upon medical evidence and whether the disability is expected to last a minimum of 12 months or for the remainder of the person's life.	$83,908,925
DHS-DDD	ICFDD - Day Program	Active Treatment		$80,078,700
DHS-DDD	Grant Programs	Prevent Out of Home Placement		$78,193,300

DHS-DDD	Adult - Home Based	Prevent Out of Home Placement		$63,075,800
DHS-DRS	Illinois School for the Deaf	Offers programs for students who are deaf and hard of hearing that are designed to prepare students for transition into the world of work or post-secondary education after graduation.	Located in Jacksonville, is a state-operated residential facility that offers an accredited birth to three-year-old program, preschool, elementary and high school academic programs for children with a severe hearing impairment. ISD also offers vocational and technology training programs, social and health services, and recreational activities.	$18,238,616
DHS-DDD	Child Group Home	Residential		$16,919,000
DHS-DDD	Child Res. School	Residential		$16,099,400
DHS-DDD	Ind. Service & Supt Advocacy	Waiver Required Service		$14,437,200
DHS-DDD	State-Op Day Programs	Active Treatment		$13,910,000
DHS-DDD	Child - Home Based	Prevent Out of Home Placement		$13,353,900
DHS-DDD	CILA - FFS (res only)	Residential		$10,509,400
DHS-DRS	Illinois School for the Visually Impaired	Offers programs for students who are visually impaired that are designed to prepare students for successful living and independence.	A state-operated residential facility that offers an accredited birth to three-year-old program, preschool, elementary and high school academic programs for children with a severe visual impairment. ISVI also offers vocational and technological training programs, social and health services, orientation and mobility training, and recreational activities.	$9,544,143

DHS-DDD	Comm Liv Fac (res only)	Residential		$8,976,600
DHS-DDD	Respite	Prevent Out of Home Placement		$7,006,500
DHS-DRS	Centers for Independent Living	Funding for community based non-for-profit organizations that provide systems advocacy to create options and choices for independent living. CILs provide services to individuals to help them in increasing skills and abilities for independent living and provide public awareness. Core services provided by all CILs include advocacy, peer counseling, skills training information and referral.	CILS serve three major functions: Systems advocacy to eliminate environmental, economic, communication, civil and human rights barriers; Training and Direct Services that offer choice options to consumers hat encourage them to make their own decisions about how they live; and Public education to promote awareness of disability and accessibility to create equal opportunities for persons with disabilities throughout their communities.	$6,386,815
DHS-DRS	Illinois Center for Rehabilitation & Education - Roosevelt	Prepares young people with severe physical disabilities for a successful adult life. Program opportunities provide students to learn a wide range of skills, including daily living, vocational, empowerment/self-advocacy, social/leisure, and mobility using public transportation resources.	Located in Chicago, is a state-operated residential facility that provides elementary and second education programs for students ages 5 - 21 who have severe physical disabilities and associated chronic health conditions and who are unable to attend the local public school because the school district is unable to meet the student's needs. Other services include: occupational, physical and activity therapies; vocational evaluations and training; job and life coaching; 24-hour nursing; medical services; social worker services; psychological evaluations; recreational therapies, and other services.	$5,519,200
DHS-DDD	Therapies (Waiver)	Waiver Required Service		$4,781,300

DHS-DDD	Specialized Services	Court Ordered		$4,245,800
DHS-DDD	Family Asst. Program	Prevent Out of Home Placement		$3,111,500
DHS-DRS	Client Assessment Unit	Provide medical determinations of employability for Transitional Assistance and Medicaid based on a disability.	Prevents unnecessary payment of benefits at state cost to individuals who are ultimately found ineligible.	$2,236,500
DHS-DDD	Equip/Modifications (Waiver)	Waiver Required Service		$2,091,700
DHS-DRS	Illinois Center for Rehabilitation & Education - Wood	Provides a concentrated, short term residential program for adults who are newly blind or visually impaired.	Participants receive training in mobility, orientation and activities of daily living tailored to meet each participant's needs.	$1,792,500
DHS-DRS	Older Blind	Provides independent living services to individuals 55 years of age and older who are blind; conduct activities that will improve or expand services for these individuals; and conduct activities to improve public understanding of the problems facing these individuals.	Services are provided to help persons served under this program adjust to their blindness by increasing their ability to care for their individual needs.	$1,422,772
DHS-DRS	Assistive Technology	Promotes availability of assistive technology used by individuals with disabilities in order to perform functions that might otherwise be difficult or impossible.	Makes assistive technology devices and services more available and accessible to individuals with disabilities and their families. and provides services and programs to provide independence in recreation, education, vocational and daily living activities for people with disabilities.	$589,938
DHS-DRS	Client Assistance Program	Provides assistance and advocacy for customers or applicants of DRS	Work with customers to answer questions or resolve any problems or issues in order to prevent delays in services, enhances the opportunity for a successful outcome and usually eliminates the process of having to go through an appeal process.	$516,714

SUBSTANCE ABUSE

Overview

Substance use disorders are preventable and manageable diseases, with recovery rates higher than most cancers.[1] Society often perceives these disorders as consequences of irresponsibility, personal deficiencies, or immorality, however, the Principles of Effective Treatment, established by the National Institute on Drug Abuse (NIDA), point to other reasons: "Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences[2]." Effective treatment programs and systems reflect this scientific reality.[3]

In Illinois, substance use disorders are addressed through two main systems of care: 1) alcohol tobacco and other drug prevention and, 2) the treatment of substance use disorders. These service areas fall under the domains of the Illinois Department of Human Services' (DHS) Divisions of Alcohol and Substance Abuse (DASA, for treatment) and Community Health and Prevention (CHP, for prevention). Providers under the agency delivered services to more than 90,000 individuals in FY 09.

About five percent of treatment dollars originate in the adult or juvenile corrections programs (Department of Corrections [DOC], Department of Juvenile Justice [DJJ], respectively). These programs will be detailed separately in this discussion.

In Illinois, the demand for treatment outstrips treatment supply by a ratio of at least 14 to 1. As outlined below, this unmet treatment need costs Illinois' taxpayers $4.6 billion in costs absorbed by other public systems like education, health, and the criminal justice system. This amounts to one-third of Illinois' deficit or $363 for each man, woman and child in Illinois.[4]

In 2005, Columbia University's National Center on Addiction and Substance Abuse ranked Illinois 13th in per capita spending for treatment, prevention and research programs[5]. However, these rankings do not adjust for treatment need within each state, an important caveat since substance use rates and unmet demand for treatment are high within Illinois. In addition, this ranking preceded the budget cuts that have taken place since 2005, which likely dropped Illinois' substance abuse and prevention spending rank to a much lower level.

TREATMENT SERVICES

DASA oversees the entire substance abuse treatment system in Illinois. In 1997, the formerly named Department of Alcohol and Substance Abuse lost its independent cabinet-level agency status and was placed under the Department of Human Services. In 1999, DASA was designated as the lead agency for substance use issues. In this capacity, DASA undertakes a number of activities, including: licensing non-

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[1] McClellan http://jama.ama-assn.org/cgi/content/abstract/284/13/1689?view=short&fp=1689&vol=284&lookupType=volpage
[2] http://www.drugabuse.gov/PODAT/Principles.html
[3] http://www.drugabuse.gov/PODAT/Principles.html
[4] http://www.jointogether.org/resources/shovelingup/shoveling-up-ii-final.pdf
[5] http://www.jointogether.org/resources/shovelingup/shoveling-up-ii-final.pdf

hospital based alcohol and drug treatment programs, approving Medicaid payments for treatment services, monitoring the use of funds and delivery of services under both the federal Substance Abuse Prevention and Treatment (SAPT) block grant and the Illinois GRF (General Revenue Fund).[6],[7]

Alcohol and drug treatment services in Illinois are provided through a combination of private and publicly funded community agencies, as well as some government entities (e.g. county or multicounty health departments, correctional facilities).[8] Although all licensed, non-institutional alcohol and drug treatment providers follow the same licensing guidelines set forth by Illinois Administrative Code, they differ in terms of funding streams, and thus differ in their interaction with DASA. Private, community-based facilities operate as non-DASA funded entities and generally receive payments through private insurance or client self-pay, though some will also accept Medicaid/Medicare and state-insured clients. Public, community-based facilities operate in whole or part as DASA-funded entities and receive federal Substance Abuse Prevention and Treatment (SAPT) block grant or Illinois GRF dollars to provide services through a contracted Community Service Agreement.[9]

Various other institutions provide alcohol and drug treatment services in Illinois. In the correctional system, DOC, DJJ and the Cook County Department of Corrections all provide some degree of substance use treatment within their facilities. Veterans Administration hospitals, as well as private for-profit and non-profit hospital systems, also provide both inpatient and outpatient adult treatment services. [10]

PREVENTION SERVICES

In 1997, prevention services were moved from DASA to Community Health and Prevention (CHP), which is housed under the Department of Human Services. CHP provides a wide-range of prevention services: child well-being, domestic violence prevention, nutrition services, responsible parenting education as well as the prevention of alcohol and substance use among young people. [11]

Populations Served

According to the Illinois Household Survey, about 1.5 million Illinoisans have untreated substance use disorders.[12] According to the national Household Survey on Drugs and Health, Illinois ranked 30th in the nation for unmet treatment need for illicit drugs disorders (2.62 percent[13] of the population aged 12 and older) and 14th in the nation for alcohol use disorders (roughly 8.5 percent of the population aged 12 or older).[14] As these data suggest, more than 1.5 million Illinois residents need substance use treatment for either drugs or alcohol. Demand for treatment outstrips the supply by a ratio of nearly 14:1.[15]

According to survey data compiled by University of Illinois researchers, waiting lists across Illinois' treatment facilities vary based on treatment modality and region. Approximately 7,500 individuals, both

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[6] http://www.srl.uic.edu/publist/DASA/IL_Social_Indicator_2005.pdf
7 http://www.srl.uic.edu/publist/DASA/IL_Household_Survey.pdf
8 http://www.dhs.state.il.us/page.aspx?item=33611
9 http://www.dhs.state.il.us/page.aspx?item=32256
10 In other words, and as noted elsewhere, other units of government are involved in the human services system; however, this report focuses on the eight state agencies under the Illinois Human Services Commission Executive Order.
11 http://www.dhs.state.il.us/page.aspx?item=31754
12 http://www.srl.uic.edu/publist/DASA/IL_Household_Survey.pdf
13 http://www.oas.samhsa.gov/2k4/stateGaps/stateGaps.htm
14 http://www.oas.samhsa.gov/2k4State/AppB.htm#TabB.22
15 Demand for treatment: 1.5 million, individuals served: 90,000

youth and adults, were waiting for treatment in 2008. The longest wait times occurred at methadone maintenance clinics (139 days), adult inpatient treatment and adult residential care (both 36 days). Men have historically entered Illinois' publicly funded treatment facilities at much higher rates than women and this trend has remained stable since 1992. Men were treated for substance use disorders at a rate of nearly 2:1 as compared to women.[16]

Treatment admissions, for the large part, have remained relatively stable across racial and ethnic groups from 1992 to 2008. The largest number of treatment episodes in 2008 occurred among whites (45 percent), while African American treatment admissions remained stable during this period. Treatment admissions among Latinos increased by a modest two percent.[17]

Significant changes have occurred in the ages of those treated under Illinois publicly funded treatment systems. The age of most individuals entering treatment is rising. In 1992, more than 41 percent of individuals treated for substance use disorders were aged 24-35, compared to just one quarter in 2008. One of the largest treatment increases occurred among those aged 45 to 54, which experienced a 400 percent increase from 1992 to 2008. From 1992 to 2008, treatment admissions for those aged 55 and older nearly doubled, from about two percent in 1992 to nearly five percent in 2008. The only exception to the aging of the treatment population was among those under age 18. This group experienced a slight increase, from eight percent of the total treatment admissions in 1992 to 11 percent in 2008.[18]

Treatment admissions into Illinois' publicly funded treatment facilities have been affected by changes in drug use patterns. Drugs that were once considered "inner-city" drugs, such as heroin, are now often found in rural and suburban areas.[19] These substance use trends are apparent in publicly funded treatment data. In 1992, the majority of individuals using publicly funded treatment – nearly 60 percent – were treated for alcohol use disorders. In 2008, however, less than one-third of individuals entered treatment for alcohol. In 2008, individuals entering treatment for heroin made up more than one-quarter of treatment admissions overall, making heroin the number one illicit substance used by people who received treatment. In addition, individuals treated for marijuana experienced a four-fold increase, while admissions for cocaine use have declined by more than one-quarter. Despite concerns about methamphetamine, the number and percentage of those treated in Illinois is relatively small and has stabilized at about one percent of the treatment population.[20]

Providers must give community-based treatment service priority to targeted populations in the following ranked order: (1) pregnant women who inject drugs, (2) pregnant and postpartum women, (3) individuals with HIV-positive status and individuals who inject drugs. The following targeted population service areas may be prioritized by the individual facilities: (1) parents with alcohol and/or drug dependence, (2) DCFS, TANF (Temporary Assistance to Needy Families), DOC or TASC (a nonprofit that is the designated liaison agency) treatment service referrals.[21] The targeted service priority designations have had the benefit of redressing historical gaps in service provision or highlighting vulnerable populations. However, there has been some duplication of priority service coverage. Pregnant women, for example, are identified as service priorities under DASA, Medicaid, TANF and the SAPT block grant, resulting in a quadrupled prioritization of service.

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[16] SAMHDA on-line analysis
[17] SAMHDA on-line analysis
[18] SAMDA on-line analysis
[19] http://legacy.roosevelt.edu/ima/pdfs/heroinAnalysis.pdf
[20] SAMHDA on-line analysis
[21] http://www.dhs.state.il.us/page.aspx?item=34259

Service Delivery System

REFERRALS

The most common way for individuals to enter the treatment system is through a criminal justice system referral (e.g. as a condition of probation or parole, a prisoner re-entry referral, a court referral, an alternative to incarceration program referral). The largest percentage of individuals – more than 35 percent – receiving treatment in Illinois through publicly funded treatment were referred by some part of the criminal justice system. The majority of criminal justice system referrals—nearly 60 percent—came from probation, parole or prison re-entry referrals. Twenty percent of those sent to treatment by the criminal justice system were referred directly by the court (including drug and mental health courts) or through TASC. Just over 12 percent of criminal justice referrals were from motor vehicle (DUI, DWI) cases. The remaining criminal justice referrals came from programs that attempt to divert criminal justice cases to treatment rather than prison.[22]

Self-referral is the second most common way for individuals to enter the public treatment system. A "self-referral" indicates that the individual seeks treatment of their own initiative, without being sent by an employer, other health care provider, or community agency. In 2008, nearly one-third (31.5 percent) of those entering public treatment were self-referred. Individuals are also referred to treatment by other drug treatment providers (14 percent), other health care providers (9 percent), other community agencies (8 percent), through school (1.7 percent) or by his or her employer (less than 1 percent)[23].

ALCOHOL AND DRUG TREATMENT

In FY 97, DASA aligned their service delivery terminology and programs with that of the American Society of Addiction Medicine,[24] thereby grouping all services under the following "levels of care": [25]

- Level I – Outpatient (group or individual)
- Level II – Intensive Outpatient/Partial Hospitalization (group or individual)
- Level III – Inpatient Subacute/Residential
- Level IV – Medically Managed Intensive Inpatient

A variety of facility types provide these services in Illinois.[26] Treatment, detoxification and medication-assisted therapy services are provided in both residential or outpatient settings. Residential options include both short-term (30 days or less) and long-term (more than 30 days) treatment in private residential facilities or in the inpatient alcohol and drug/mental health ward of a traditional hospital. Post-treatment residential recovery options include transitional living sites, halfway houses and recovery homes. Partial hospitalization / intensive outpatient treatment is the intermediary stop between residential and outpatient settings. Individuals in a partial hospitalization setting generally receive services in the facility between five to eight hours during the day, but return to their own residence in the evening following treatment. Outpatient options include treatment in office-based

[22] SAMHDA on-line analysis
[23] SAMHDA on-line analysis
[24] http://www.srl.uic.edu/publist/DASA/IL_Social_Indicator_2005.pdf
[25] http://www.ilga.gov/commission/jcar/admincode/077/077020600D04010R.html
[26] http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/LicenseDirectorybyCounty.pdf

private, public or government facilities (e.g. county mental health center, county public health department).

The most recent DASA report lists 850 DASA-licensed alcohol and drug treatment facilities in Illinois.[27] In Chicago, 232 treatment sites are in operation, and in suburban Cook County, there are 66. In the collar counties of DuPage, Kane, Lake, McHenry and Will, 178 treatment sites are currently providing alcohol and drug treatment. A total of 338 treatment sites operate in the remaining Illinois counties.

Ancillary substance use treatment services available through private and public institutional and community-based facilities include: case management services, inpatient/outpatient detoxification, DUI evaluation and education, medication-assisted therapy (e.g. methadone), residential extended care (e.g. recovery homes and halfway houses), psychiatric evaluation and medication monitoring. Additional community intervention and support services include: early intervention services for individuals, community programming, HIV counseling and testing and toxicology services.[28] Research demonstrates that when individuals are connected to long term aftercare and supportive services, tailored to the individuals' needs (e.g., housing, job training, educational programming) this has a positive impact their ability to stay in recovery.

The State Methadone Authority under DASA regulates medication-assisted therapy in Illinois. [29] These facilities may provide either methadone maintenance or methadone detoxification services. These services are generally provided in an outpatient setting, though methadone detoxification may be provided in an inpatient setting. DASA facilities are currently unable to provide, except on a very limited basis, buprenorphine (Suboxone) maintenance and detoxification services for opiate dependence in Illinois due to funding limitations.[30]

Services for co-occurring disorders (concurrent substance use and mental health disorder) do not appear to be coordinated at the state-level through DASA, DHS's Division of Mental Health (DMH) or a cooperative agreement between the two state agencies. DASA-licensed treatment facilities must develop treatment plans that include referrals or consultations for mental health treatment if so indicated following patient assessment.[31] Under DMH community-based provider regulations, individuals experiencing co-occurring substance use and mental health disorders are not to be excluded from services, but should rather be given special consideration and involved in an integrated substance-mental health treatment program if available.[32] Contracted providers report that the lack of coordination and service delivery models means that it is difficult to find services for clients with co-occurring disorders, as there is no standardized mechanism to reimburse facilities for providing it.[33]
In terms of geography, service provision in the Chicago Metropolitan Area is generally more fragmented, with community-based substance use treatment and mental health treatment provided by different facilities. This contrasts with service provision in other areas of the state. Outside of the Chicago

[27] http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/LicenseDirectorybyCounty.pdf. Note that these are not 850 unique treatment agencies, but are 850 unique sites in which treatment is provided, as some of the larger treatment systems have multiple offices in multiple communities.
[28] http://www.dhs.state.il.us/page.aspx?item=34259
[29] http://www.nasadad.org/resource.php?doc_id=2007
[30] Telephone interview, DASA Employee. April 19, 2010.
[31] http://www.ilga.gov/commission/jcar/admincode/077/077020600D04210R.html. This is also discussed in the Mental Health section of this report.
[32] http://www.dhs.state.il.us/page.aspx?item=34251
[33] Treatment Service Provider Interviews conducted by Illinois Consortium on Drug Policy at Roosevelt University, April 22, 2010.

Metropolitan Area, many DASA-licensed treatment providers also provide mental health services. In central and southern Illinois, agencies are larger and are concentrated on the county level, thus consolidating both substance use and mental health treatment in one comprehensive facility. Clients in these facilities may be more likely than their urban peers to receive integrated substance use and mental disorder treatment.[34]

PREVENTION SERVICES

Prevention funds are allocated to approximately 120 community-based providers to deliver prevention services across the state. These providers do not compete for grant monies, but rather are selected to deliver services. These providers are charged with the tasks of determining the alcohol, tobacco and other drugs (ATOD) community prevention needs, broadcasting prevention messages, coordinating professional development for prevention professionals and maintaining resource centers.[35].

DASA's Bureau of Community-based and Primary Prevention (BCPP), along with the Substance Abuse Prevention Program (SAPP), divide the state of Illinois into 5 service regions, each consisting of numerous cities and townships. In Region 1, which includes Chicago and its suburbs, there are 24 and 12 prevention providers, respectively. Region 2, which includes municipalities in northern Illinois, has 17 prevention providers. Regions 3 and 4, covering central Illinois, have 30 prevention providers. Region 5, covering southern Illinois, has 15.[36]

Funding

FY 10 budget data by DHS, DJJ and DOC summarize the funding levels for treatment and prevention services, and reveal that the vast majority of funds are devoted to programs operating outside of the corrections system:

FY 10 Budget Data for Substance Abuse Services

	Total
	$ 271,234,667
Substance Abuse Services in Correction Systems	$ 14,052,867
Substance Abuse Services for General Population	$ 257,181,800

TREATMENT

Treatment funding is provided through three main sources in Illinois: Medicare/Medicaid payments, Illinois General Revenue (GRF) and federal Substance Abuse Prevention and Treatment (SAPT) block grant dollars. There are some misconceptions about how these sources are used to pay for treatment in Illinois, as well as the impact that impending budget problems will have on these funding streams.

First, there is a mistaken belief that Medicaid covers a large portion of treatment costs in Illinois. In reality, roughly 80 percent of potential treatment recipients are not eligible for Medicaid services. Individuals may qualify for Medicaid if they are blind, disabled or aged, have children under the age of

[34] Treatment Service Provider Interviews conducted by the Illinois Consortium on Drug Policy at Roosevelt University. April 22, 2010.
[35] https://www.prevention.org/Professionals/ProfDev/Provider.asp
[36] https://www.prevention.org/Professionals/ProfDev/Provider.asp

19, are pregnant, or are children, subject to income limitations.[37,38] Individuals who receive Supplemental Security Income (SSI) and Medicare may also qualify for Medicaid.[39] Medically needy individuals may also be covered under Medicaid if medical costs reduce income to well below the federal poverty level (FPL). All TANF recipients qualify for Medicaid benefits.[40]

Medicaid income qualifications are dependent on the population served, though all income eligibility requirements are tied to FPL guidelines and participants must be citizens (except for children). For example, parents cannot earn more than 185 percent of the FPL (e.g. about $33,000 for a family of three). For pregnant women and infants, the income level eligibility requirement is 200 percent of the FPL (e.g. about $36,000 for a family of three). Children may qualify for Medicare if their family earns no more than 133 percent of the FPL (about $24,000 for a family of three), though they will qualify for other medical care under Illinois All Kids program. For Medically Needy individuals, incomes requirements are stricter: an individual must earn just 39 percent of the federal poverty line after medical expenses (or just $7,100 for an individual).[41]

Additionally, the lack of Medicaid benefit limits on certain services – particularly youth residential services – creates the potential for Medicaid overspending. When this occurs, the state is obliged to use GRF dollars to fill the gap in Medicaid spending.

This in turn reduces available GRF monies for uninsured treatment recipients and has the additional consequence of potentially threatening federal SAPT block grant dollars. The latter dollars are dispersed to DASA with a Maintenance of Effort (MOE) requirement. The MOE requirement states that DASA must maintain spending equal to the average of the previous two years' spending or risk losing a federal dollar for every state dollar not spent. If the state is unable to come up with the expected dollar amount for treatment funding, a waiver may be applied in the short-term, but eventually budget shortfalls affect the amount of money received through the block grant.

More than one quarter of total treatment funding comes from federal block grants and 60 percent is allocated from the GRF. Other dollars come from a variety of funds such as welfare reform monies, the alcoholism and substance abuse fund, the drunk and drugged driving fund, etc. Together, funding for DASA for substance abuse treatment services totals $237,026,300. Total funding for treatment of substance use disorders declined more than 8.5 percent from FY 09 to FY 10. According to the Illinois Association of Alcoholism and Drug Dependence Association (IADDA), projected cuts for FY 11 are expected to be another eight percent.

For treatment in the corrections system, DOC spent $11,903,100 for treatment of substance use in its corrections programs, which include the Sheridan Correctional Facility, probation and parole. The amount allocated for corrections spending did not decrease from FY 09 to FY 10. DJJ was allocated $2,149,767 for spending on treatment for substance use disorders. This is the one area in all of substance use treatment and prevention that saw an increase in spending—13 percent—from FY 09 to FY 10.

[37] http://healthinsuranceinfo.net/getinsured/illinois/financial-assistance/medicaid/
[38] http://www.dhs.state.il.us/page.aspx?item=29722
[39] Ibid.
[40] Ibid.
[41] Ibid.

It should also be noted that Illinois levies an alcohol excise "sin" tax. These funds are routed to the Capital Development Fund and are not currently allocated to any alcohol or drug treatment programming.

PREVENTION

Prevention funding is quite scarce in Illinois. Last year, the federal government cut entirely the Safe and Drug Free Schools Funding (SDFS) Program for FY 11, citing uneven effectiveness and lack of implementation of evidenced-based practices.[42] Therefore, prevention activities across school districts will now be uneven. The Illinois Board of Education (ISBE) cites a number of learning standards for drug education and prevention. However, interview data with prevention and educational professionals indicate that this education is generally confined to a two-week period during health class. In addition to funding shortfalls, schools cite the difficulty of implementing comprehensive ATOD prevention programs following the passage of No Child Left Behind (NCLB) legislation. School districts express concern over spending time outside of core subject areas for fear of lowering their students' test scores and not meeting NCLB standards.

About 50 percent of prevention funding at the state level is funded through block grants, with less than 20 percent of funding coming from the GRF. Total funds spent on prevention equaled $20,155,500. Though prevention funding has declined just two percent overall over the past year, general revenue spending declined nearly 20 percent from FY 09 to FY 10.

Critical Issues and Trends

The majority of substance-related monies—at both the state and federal level—are spent not on prevention, treatment and research but on the costs that result from *not* providing these services.[43] Aside from the harm caused by untreated substance use disorders at the individual, family, community and state levels, the cost of untreated substance use disorders is immense. In Illinois, out of each dollar spent on substance use disorders, less than 3.7 cents is spent on treatment and prevention and less than one cent is spent on alcohol and tobacco taxation and regulation.

Where does the rest of that dollar go? Criminal justice costs related to substance use equal 25 cents of that dollar (or 3.6 percent of the state budget at $1.1 billion). Health care costs comprise 31 cents of the substance use dollar (or 4.4.percent of the entire state budget at $1.4 billion). Child and family assistance makes up 20 cents of the substance use dollar (or 2.9 percent of the entire state budget at $2.9 billion). This leads many to conclude that funding treatment at an adequate level will reduce state budget costs across all of the aforementioned areas.[44]

[42] http://www2.ed.gov/about/overview/budget/budget10/summary/edlite-section4.html . Most of the SDFS monies were used for student assistance programs in the schools. These programs enhanced collaboration between parents, students, faculty, and community agencies to "address barriers to learning," including substance use disorders and other behavioral problems. Prevention First: https://www.prevention.org/EducatorsAndSchools/SAC/SAC_AboutUs.asp. School districts may also choose to apply for prevention grant funds through foundations or other sources and/or provide prevention activities with their own funds. Additionally, they may turn to an existing community-based program for prevention services.

[43] http://www.jointogether.org/resources/shovelingup/shoveling-up-ii-final.pdf

[44] http://www.jointogether.org/resources/shovelingup/shoveling-up-ii-final.pdf

More than 14 percent of the Illinois state budget is spent on the untreated costs of addiction, translating to roughly $363 of untreated addiction-related costs for every man woman and child in Illinois. This totals $4.6 billion, nearly one-third of Illinois' current deficit.[45]

In addition to this cost concern, the following issues and trends are important to consider:

- Currently, little coordination exists for serving individuals with co-occurring disorders, despite the fact that some treatment centers have co-occurring rates as high as 80 percent. Under NIDA's Principles of Effective Treatment,[46] effective care for substance use disorders *must treat both* the substance use disorder and the other mental health disorder at the same time.[47]

- Scarce funding has created high levels of need for substance use treatment. During economic declines, the prevalence of substance use disorders tends to rise. As individuals lose jobs, the rates of those insured—and able to assess treatment services through private channels—tends decrease. Added to these trends are the cuts in funding for treatment of substance use disorders, which puts an additional squeeze on the underfunded system. These factors have resulted in three populations that might not receive adequate care or have a harder time accessing care:

    - Impoverished but non-Medicaid eligible individuals with multiple needs and barriers.
    - Working individuals without access to substance use treatment because of insurance restrictions.
    - The recently unemployed.

    Further, the existing system of care does not often address consumer-identified goals and outcomes. When the state spends money on detox programs with no community follow-up, this is only a partial investment in the solution, which minimizes the value of the treatment.

- When a state overspends on Medicaid, it lands in the precarious position of either losing the Medicaid match of $.50 on the dollar or shifting those spent dollars to federal block grant programs so that it may continue to receive a dollar-for-dollar match. In either case, in order to get federal reimbursements, the GRF allocation must remain at stable levels—without reductions—in order to remain compliant with SAPT Block Grant's own maintenance of effort requirements. Failure to satisfy these demands potentially means the loss of federal Medicaid reimbursement (currently available at the increased ARRA match rate) and the potential loss of more than $70 million in federal block grant funding.

- There have been service cuts in all types of alcohol and drug treatment, including both residential, outpatient and detoxification services. Medically-assisted treatment (MAT) programs are particularly underfunded. MAT services include methadone and buprenorphine detoxification and maintenance for opiate dependence. With the increase in heroin use as the second most common reason for entering publicly funded treatment in Illinois, this issue is particularly pertinent now.

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[45] http://articles.chicagotribune.com/2010-02-23/news/ct-met-state-budget-mess-20100223_1_state-budget-illinois-spending-cuts

[46] http://www.drugabuse.gov/PODAT/Principles.html

[47] http://www.drugabuse.gov/PODAT/Principles.html

- Providers report that adjustments have not been made to treatment monies to keep up with cost of living increases, effectively reducing client treatment capacity as providers reduce the amount of services they can provide. Additionally, grant and performance-based contract requirements obligate providers to furnish six-month or 12-month outcomes data on clients served, necessitating staff time reallocations away from service delivery and towards unfunded administrative activities.

Human Service Category: Substance Abuse

Data Source: State agencies as indicated in the first column

Substance Abuse Services in Correction Systems

Agency	Program Name	Purpose	Key Outcomes	FY 10 Budget
DOC	Substance Abuse Treatment	To provide facility based substance abuse treatment to adult population	To reduce the prevalence of substance abuse by inmates committed to the Department's custody	$11,350,400
DJJ	Substance Abuse Treatment	To provide facility based substance abuse treatment to juvenile population	To reduce the prevalence of substance abuse by youth committed to the Department's custody	$2,149,767
DOC	Men's Reentry Program	To provide substance abuse interventions in a community correctional settings (ATC); provide post reentry case management for offenders in Chicago; expand the availability of transitional and continuing aftercare treatment options for offenders with SA issues	To reduce drug use/abuse and criminal behavior through substance abuse interventions and community based reentry programming	$552,700

Substance Abuse Services for General Population

DHS-ASA	Addiction Treatment and Recovery Support services	DASA offers a comprehensive and coordinated community-based array of services for the prevention, intervention, treatment, and rehabilitation of alcohol and other drug abuse and dependency. Services include: Treatment Services: Level I (Outpatient), Level II (Intensive Outpatient), Level III.1(Residential Extended Care), Level III.2-D, III.7-D and IV-D (Detoxification), Level III.5 (Residential Rehabilitation); and Ancillary Treatment, Intervention or Support Services	DASA is in the process of developing Performance Based Contracting. Measures are being developed for all services to improvement engagement and retention in treatment.	$237,026,300
DHS-CHP	Substance Abuse Prevention	To reduce alcohol, tobacco, and other drug (ATOD) use among youth.	Reduce Substance Abuse	$16,373,600

DHS-CHP	Strategic Prevention Framework	The Strategic Prevention Framework is five components designed to assist the State and communities build capacity and the infrastructure necessary to implement and sustain culturally competent and effective prevention policies, practices and programs.	Reduce Substance Abuse	$3,781,900

APPENDIX A: HUMAN SERVICES ACRONYMS

The following acronyms are frequently used throughout this report.

AAA	Area Agencies on Aging
AABD	Aid to the Aged, Blind, and Disabled
ADA	Americans with Disabilities Act
AFDC	Aid to Families with Dependent Children
ARRA	American Recovery and Reinvestment Act
ATOD	Alcohol, tobacco and other drugs
CBAE	Community Based Abstinence Education
CHIP	Children's Health Insurance Program
DCEO	Department of Commerce and Economic Opportunity
DCFS	Department of Children and Family Services
DHFS	Department of Healthcare and Family Services
DHS	Department of Human Services
DJJ	Department of Juvenile Justice
DOA	Department on Aging
DOC	Department of Corrections
DPH	Department of Public Health
EBT	Electronic Benefits Card
EITC	Earned Income Tax Credit
EOA	Economic Opportunity Act
FCRC	Family Community Resource Centers
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FSP	Food Stamp Program
GA	General Assistance
GRF	General Revenue Funds
HBWD	Health Benefits for Workers with Disabilities
HCBS	Home and Community Based Services
ICF/DD	Intermediate Care Facilities for the Developmentally Disabled
IMD	Institute for Mental Diseases
ISBE	Illinois State Board of Education
LIHEAP	Low Income Home Energy Assistance Program
MOE	Maintenance of Effort
OAA	Older Americans Act
PCCM	Primary Care Case Management
PRWOA	Personal Responsibility and Work Opportunity Act
RFP	Request for Proposals
SAPT	Substance Abuse Prevention and Treatment
SASS	Short Term Assessment, Crisis, Linkage and Triage System
SCHIP	State Children's Health Insurance Program
SNAP	Supplemental Nutrition Assistance Program
SSDI	Social Security Disability Insurance

SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TEFAP	The Emergency Food Assistance Program
VAWA	Violence Against Women Act
VISTA	Volunteers in Service to America
WIA	Workforce Investment Act
WIC	Special Supplemental Food Program for Women, Infants and Children
WIN	Work Incentive Program

APPENDIX B: EXECUTIVE ORDER

EXECUTIVE ORDER **09-20**

EXECUTIVE ORDER CREATING THE ILLINOIS HUMAN SERVICES COMMISSION

WHEREAS, the State of Illinois depends upon public and private service providers to deliver many critical human services necessary to protect and enhance the welfare of its citizens, including its most vulnerable populations; and

WHEREAS, the citizens of Illinois and their communities depend upon these services to protect public health, create individual and family well-being, improve public safety, revitalize local economies, and enhance learning; and

WHEREAS, human services play a vital role in every community and legislative district across the state, providing jobs and revenue in addition to services and supports to children and youth, families, workers, the elderly, people with disabilities, and other vulnerable populations; and

WHEREAS, a strong and well-managed network of public and private human services is integral to the achievement of other state goals in the areas of health and wellness, educational outcomes, workforce development, and an improved business climate; and

WHEREAS, a lack of adequate appropriations, clear goals, spending priorities, and measurable outcomes along with delays in payments, inadequate rates, duplicative reporting requirements, and other systemic barriers prevent private entities from achieving the goal of a strong and effective network of well managed public and private service providers; and

WHEREAS, the maintenance of a strong and well managed network of human services requires a joint planning process that brings together public and private experts in human services to identify best practices and strategies.

THEREFORE, I, Pat Quinn, Governor of Illinois, pursuant to the supreme executive authority of the Governor as set forth in Article V, Section 8 of the Illinois Constitution, do hereby order as follows:

I. CREATION

There is hereby established the Illinois Human Services Commission (hereinafter "Commission").

II. PURPOSE

The Commission shall undertake a systematic review of human services programs with the goal of ensuring their consistent delivery in the State of Illinois.

III. DUTIES

The Commission shall make recommendations for achieving a system that will provide for the efficient and effective delivery of high quality human services. These recommendations shall include the following elements:

a. ensuring adequate appropriations for the provision of human services

b. establishing processes for determining fair, adequate and timely reimbursement

c. maintaining efficient management of publicly-funded programs and services

d. implementing best practices within the human services field

e. creating outcome measures and accountability mechanisms

f. developing projections for future human services need based on demographic trends and other related variables

The Commission shall make best efforts to:

a. Use existing reports, research, and planning efforts and call for additional reports and research to support its work.

b. Seek input from existing advisory councils and task forces that address human service delivery as well as other human services experts and the public-at-large including one or more public hearings to take and consider public comment.

c. Identify opportunities for increased efficiency and/or cross-agency collaboration regarding human services delivery.

IV. MEMBERSHIP

The Commission shall include representation from both public and private organizations, and its membership shall reflect regional, racial, and cultural diversity to ensure representation of the needs of all Illinois citizens.

The Governor appoints all members of the Commission. The Commission will include the following:

a. A co-chair from the Office of the Governor and a co-chair not employed by a governmental entity to represent the interests of non-governmental organizations;

b. Eight members of the General Assembly representing each of the majority and minority caucuses of each chamber;

c. The Directors or Secretaries of the following State agencies or their designees:

1. Department of Human Services;

2. Department of Children and Family Services;

3. Department of Healthcare and Family Services;

4. State Board of Education;

5. Department on Aging;

6. Department of Juvenile Justice;

7. Department of Corrections;

8. Department of Public Health;

d. Local government stakeholders and nongovernmental stakeholders with an interest in human services, including representation among the following private-sector fields and constituencies:

1. early childhood education and development;

2. child care;

3. child welfare;

4. youth services;

5. developmental disabilities;

6. mental health;

7. employment and training;

8. sexual and domestic violence;

9. alcohol and substance abuse;

10. local community collaborations among human services programs;

11. immigrant services;

12. affordable housing;

13. re-entry;

14. food and nutrition;

15. homelessness;

16. older adults;

17. physical disabilities;

18. business;

19. philanthropy;

20. labor;

21. and law enforcement.

Members shall serve for the duration of the Commission. In the event of a vacancy, the appointment to fill the vacancy shall be made by the Governor. The Commission shall convene within 60 days after the effective date of this Order. The initial meeting of the Commission shall be convened by the co-chair selected by the Governor. Subsequent meetings will convene at the call of the co-chairs. The Commission shall meet on a quarterly basis or more often, if necessary.

V. REPORT

The Commission shall first report to the Governor and General Assembly on the Commission's progress towards its goals and objectives by June 30, 2010. Interim report dates include November 30, 2010, April 30, 2011 and a final report due no later than two years from enactment of this Commission. The Commission and the terms of its members shall expire upon delivery of the final report.

VI. TRANSPARENCY

In addition to whatever policies or procedures it may adopt, all operations of the Commission will be subject to the provisions of the Illinois Freedom of Information Act (5 ILCS 140/1 *et seq.*) and the Illinois Open Meetings Act (5 ILCS 120/1 *et seq.*). This section shall not be construed so as to preclude other statutes from applying to the Commission and its activities.

VII. SAVINGS CLAUSE

Nothing in this Executive Order shall be construed to contravene any state or federal law.

VIII. SEVERABILITY

If any provision of this Executive Order is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect.

IX. EFFECTIVE DATE

This Executive Order shall be effective upon filing with the Secretary of State.

_____

Pat Quinn, Governor

Issued by Governor: November 22, 2009
Filed with Secretary of State: November 23, 2009

APPENDIX C: SPENDING TRENDS IN STATE HUMAN SERVICES AGENCIES

Spending trends for the major state agencies that provide human services are discussed in the Overview section of this report. This appendix contains additional detailed historical spending data by state agency.

State Agency Expenditures from General Funds and All Appropriated Funds, FY 2000 to FY 2009

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009*
General Funds ($ millions)										
Total expenditures - all state agencies	22,976	24,583	24,899	23,925	25,149	26,224	27,162	28,473	30,358	33,159
Core human service agencies	9,587	10,319	10,084	9,785	10,448	9,941	11,442	11,904	12,624	14,362
Department of HealthCare and Family Services**	4,903	5,318	5,153	5,099	5,690	4,990	6,338	6,682	7,033	8,502
Department of Human Services	3,437	3,728	3,668	3,502	3,597	3,747	3,817	3,885	4,086	4,240
Department of Children and Family Services	920	920	904	824	795	754	803	771	887	929
Department on Aging	218	232	239	242	256	331	352	421	458	538
Department of Public Health	109	121	120	118	110	119	132	145	160	153
Other state agencies										
State Board of Education	4,850	5,074	5,292	5,133	5,471	5,751	6,045	6,472	6,995	7,357
Departments of Corrections and Juvenile Justice***	1,113	1,188	1,243	1,162	1,183	1,198	1,283	1,230	1,328	1,434
All other agencies	7,426	8,002	8,280	7,845	8,047	9,334	8,392	8,867	9,411	10,006
All Appropriated Funds ($ millions)										
Total expenditures - all state agencies	38,779	42,146	45,142	47,458	57,734	50,643	52,579	55,101	59,403	61,030
Core human service agencies	12,826	13,880	14,419	14,878	17,220	17,244	17,916	18,844	20,436	21,839
Department of HealthCare and Family Services**	6,778	7,428	7,907	8,540	10,699	10,507	11,089	11,780	13,053	14,149
Department of Human Services	4,242	4,564	4,579	4,485	4,669	4,800	4,867	4,978	5,227	5,437
Department of Children and Family Services	1,359	1,375	1,363	1,301	1,268	1,238	1,241	1,264	1,270	1,284
Department on Aging	261	284	298	304	314	403	421	489	527	607
Department of Public Health	186	229	272	248	270	296	298	333	359	362
Other state agencies										
State Board of Education	6,275	6,662	6,635	6,702	7,131	7,576	7,879	8,273	8,881	9,377
Departments of Corrections and Juvenile Justice***	1,190	1,271	1,332	1,245	1,256	1,285	1,244	1,319	1,415	1,508
All other agencies	18,488	20,333	22,756	24,633	32,127	24,538	25,540	26,665	28,671	28,306

* General Funds data Include FY09 Budget Relief Fund.
** Formerly Department of Public Aid (FY00-FY05). Excludes employee group insurance (FY06-FY09).
*** Department of Juvenile Justice became a separate agency in FY 2007.

Source: Budget & Tax Policy Initiative, Voices for Illinois Children; based on data from Illinois State Comptroller.

Average Annual Change in Expenditures, FY 2000 to FY 2009

	General funds	All appro-priated funds
Core human service agencies	4.8%	6.2%
Department of HealthCare and Family Services*	6.9%	8.7%
Department of Human Services	2.4%	2.8%
Department of Children and Family Services	0.3%	-0.6%
Department on Aging	10.9%	10.1%
Department of Public Health	4.1%	8.1%
Other state agencies		
State Board of Education	4.8%	4.6%
Departments of Corrections and Juvenile Justice**	3.0%	2.8%
All other agencies	3.6%	5.7%
Total - all state agencies	4.2%	5.5%
Economic indicators		
Consumer price index	2.9%	--------
Personal income in Illinois	4.2%	--------

* Formerly Department of Public Aid (FY00-FY05). Excludes employee group insurance (FY06-FY09).
** Department of Juvenile Justice became a separate agency in FY 2007.

Source: Budget & Tax Policy Initiative, Voices for Illinois Children; based on data from Illinois State Comptrolle

Percentage Distribution of State Expenditures, FY 2000 and FY 2008

	General Funds		All Appropriated Funds	
	FY 2000	FY 2008	FY 2000	FY 2008
Core human service agencies	41.7%	41.6%	33.1%	34.4%
Department of HealthCare and Family Services*	21.3%	23.2%	17.5%	22.0%
Department of Human Services	15.0%	13.5%	10.9%	8.8%
Department of Children and Family Services	4.0%	2.9%	3.5%	2.1%
Department on Aging	0.9%	1.5%	0.7%	0.9%
Department of Public Health	0.5%	0.5%	0.5%	0.6%
Other state agencies				
State Board of Education	21.1%	23.0%	16.2%	15.0%
Departments of Corrections and Juvenile Justice**	4.8%	4.4%	3.1%	2.4%
All other agencies	32.3%	31.0%	47.7%	48.3%
Total expenditures - all state agencies	100.0%	100.0%	100.0%	100.0%

* Formerly Department of Public Aid (FY00-FY05). Excludes employee group insurance (FY06-FY09).
** Department of Juvenile Justice became a separate agency in FY 2007.

Source: Budget & Tax Policy Initiative, Voices for Illinois Children; based on data from Illinois State Comptrolle

APPENDIX D: GRF FUNDING INFORMATION FOR STATE AGENCIES

The Governor's Office of Management and Budget regularly publishes detailed information on the state agencies' budgets and spending. The following charts show budgetary information for FY 10 for General Revenue Funds only, for the eight human services agencies included in the scope of the commission. This information is available at http://www2.illinois.gov/budget/Pages/Resources.aspx

Illinois Department of Children and Family Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$232,156.3**	**$250,429.6**	**$248,516.3**	**$227,321.3**	**($27,908.3)**	**$220,608.0**	**$0.0**	**$220,608.0**
Other Operations	**$54,518.0**	**$51,285.4**	**$49,508.2**	**$51,291.2**	**$0.0**	**$49,508.2**	**$0.0**	**$49,508.2**
Lump Sums	**$10,254.8**	**$10,254.8**	**$10,254.8**	**$5,127.4**	**($5,127.4)**	**$5,127.4**	**$5,127.4**	**$10,254.8**
Grants	**$610,757.2**	**$610,309.0**	**$598,192.5**	**$309,204.5**	**($288,988.0)**	**$309,204.5**	**$266,880.0**	**$576,084.5**
Children's Advocacy Centers	$2,069.5	$2,069.5	$2,069.5			$1,034.8	$1,034.8	$2,069.5
Foster Homes and Specialized Foster Care	$180,888.8	$209,896.2	$202,496.2			$108,998.1	$81,462.1	$190,460.2
Counseling and Auxiliary Services	$14,028.5	$12,128.5	$12,128.5			$6,064.3	$6,064.3	$12,128.5
Institution and Group Home Care and Prevention	$165,380.6	$174,160.3	$169,443.8			$87,080.2	$77,327.7	$164,407.8
Services Associated with the Foster Care Initiative	$6,812.2	$6,812.2	$6,812.2			$3,406.1	$3,406.1	$6,812.2
Adoption and Guardianship Services	$199,584.1	$163,448.0	$163,448.0			$81,724.0	$76,688.0	$158,412.0
Health Care Network	$4,198.5	$4,072.5	$4,072.5			$2,036.3	$2,036.3	$4,072.5
Cash Assistance and Housing Locator Services (Norman)	$1,432.0	$1,432.0	$1,432.0			$716.0	$716.0	$1,432.0
MCO (Medical Clinical Opt) Technical Assistance and Program Development	$1,650.0	$1,600.5	$1,600.5			$800.3	$800.3	$1,600.5
Pre-Admission/Post Discharge Psychiatric Screening	$3,225.0	$3,200.2	$3,200.2			$1,600.1	$1,600.1	$3,200.2
Psychological Assessments	$3,200.0	$3,273.6	$3,273.6			$1,636.8	$1,636.8	$3,273.6
Department Scholarship Program	$842.5	$817.2	$817.2			$408.6	$408.6	$817.2
Reimbursing Counties	$338.5	$338.5	$338.5			$169.3	$169.3	$338.5

Illinois Department of Children and Family Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Tort Claims	$233.8	$164.9	$164.9			$82.5	$82.5	$164.9
Protective/Family Maintenance Day Care	$25,928.5	$25,928.5	$25,928.5			$12,964.3	$12,964.3	$25,928.5
Youth in Transition Program	$944.7	$966.4	$966.4			$483.2	$483.2	$966.4
Total GRF	**$907,686.3**	**$922,278.8**	**$906,471.8**	**$592,944.4**	**($322,023.7)**	**$584,448.1**	**$272,007.4**	**$856,455.5**

Department of Corrections

FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	$936,595.7	$823,386.2	$787,962.5	$791,041.7	($14,722.9)	$773,239.6	$0.0	$773,239.6
• Staff Furlough Days						($8,419.8)	0.0	($8,419.8)
• Reduction of 18 Central Office positions						($816.4)		($816.4)
• Reduction of 413 positions						($17,320.7)		($17,320.7)
• Shortfall w/Bargaining Unit Lump Sum						$8,754.8		$8,754.8
Other Operations & Contracts	$345,370.3	$432,896.2	$348,944.9	$342,825.7	($38,612.0)	$310,332.9	$0.0	$310,332.9
							0.0	
•Facility Reorganizations						($24,216.0)		($24,216.0)
• Program reduction						($5,187.3)	0.0	($5,187.3)
• Re-entry Initiative						($23,500.8)	0.0	($23,500.8)
• Cook County Boot Camp						$1,500.0		$1,500.0
• Ceasefire						$5,625.0		$5,625.0
• Shortfall w/Operations Lump Sum & Other Ops Lump Sum						$13,286.3		$13,286.3
Lump Sums & Grants	$46,490.6	$18,957.9	$18,957.9	$13,468.0	($5,489.9)	$13,468.0	$0.0	$13,468.0
• Tort Claims	$816.2	$816.2	$816.2			$816.2		$816.2
• Sheriff's Fee's for Conveying Prisoners	$337.4	$337.4	$337.4			$337.4		$337.4
• State's Share of State's Attorney Salaries	$376.4	$376.4	$376.4			$376.4		$376.4
• Statewide Hospitalization	$9,656.3	$7,500.0	$7,500.0			$7,500.0		$7,500.0
• Frontline Staffing Lump Sum	$12,000.0	$0.0	$0.0			$0.0		$0.0
• Shared Services	$5,804.3	$7,677.9	$7,677.9			$6,900.0		$6,900.0
• Franklin County Juvenile Detention Program	$1,500.0	$1,500.0	$1,500.0			$1,500.0		$1,500.0
• Repair and Maintenance	$750.0	$750.0	$750.0			$750.0		$750.0
• Cook County Juvenile Detention Center	$7,500.0	$0.0	$0.0			$0.0		$0.0
• Cook County Boot Camp	$1,500.0	$0.0	$0.0			$0.0		$0.0
• Anit-Violence Prevention Center	$6,250.0	$0.0	$0.0			$0.0		$0.0
• Shortfall w/Lump Sums & Grants						($4,712.0)		($4,712.0)
Total GRF	$1,328,456.6	$1,275,240.3	$1,155,865.3	$1,147,335.4	($58,824.8)	$1,097,040.5	$0.0	$1,097,040.5

Department of Healthcare and Family Services

FY10 Potential Cut Scenario

$ in 000's

GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$80,394.6**	**$80,226.9**	**$71,481.8**	**$72,551.1**	**($6,841.8)**	**$64,640.0**	**$0.0**	**$64,640.0**
Other Operations	**$34,811.9**	**$33,315.3**	**$33,315.3**	**$33,118.4**	**($196.9)**	**$33,118.4**	**$0.0**	**$33,118.4**
Lump Sums	**$1,109,364.9**	**$1,358,718.8**	**$1,358,049.0**	**$1,900.0**	**($1,310,061.1)**	**$47,987.9**	**$700,000.0**	**$747,987.9**
Group Insurance	$1,057,891.0	$1,311,961.1	$1,311,961.1		($1,311,961.1)	$0.0	$700,000.0	$700,000.0
Child Support fund deposit	$38,173.4	$33,360.9	$33,360.9		$0.0	$33,360.9	$0.0	$33,360.9
Purchase of Medical Management Services	$8,155.6	$8,155.6	$7,747.8		$0.0	$7,747.8	$0.0	$7,747.8
Medical Electronic Data Interchange	$1,250.0	$1,346.3	$1,279.0		$0.0	$1,279.0	$0.0	$1,279.0
Medical Data Warehouse	$3,894.9	$3,894.9	$3,700.2		$0.0	$3,700.2	$0.0	$3,700.2
Caro v. Blagojevich legal fees	$0.0			$1,900.0	$1,900.0	$1,900.0	$0.0	$1,900.0
Medicaid	**$8,415,069.3**	**$7,573,868.3**	**$7,533,868.3**	**$6,701,016.2**	**($918,940.0)**	**$6,614,928.3**	**$300,000.0**	**$6,914,928.3**
"Grants" lump sum				$1,979,752.9	$1,933,665.0	$1,933,665.0	$300,000.0	$2,233,665.0
Physicians	$968,157.3	$865,814.4	$865,814.4	$865,814.4	$0.0	$865,814.4		$865,814.4
Dentists	$202,393.1	$224,738.3	$224,738.3	$224,738.3	$0.0	$224,738.3		$224,738.3
Optometrists	$23,122.9	$30,451.3	$30,451.3	$30,451.3	$0.0	$30,451.3		$30,451.3
Podiatrists	$5,647.8	$5,656.0	$5,656.0	$5,656.0	$0.0	$5,656.0		$5,656.0
Chiropractors	$1,870.2	$1,390.0	$1,390.0	$1,390.0	$0.0	$1,390.0		$1,390.0
Hospitals	$3,283,340.6	$2,531,282.3	$2,531,282.3	$2,531,282.3	$0.0	$2,531,282.3		$2,531,282.3
Institutions for Mental Diseases	$155,487.1	$145,298.8	$145,298.8	$145,298.8	$0.0	$145,298.8		$145,298.8
Supportive Living Facilities	$90,219.6	$128,682.3	$128,682.3	$128,682.3	$0.0	$128,682.3		$128,682.3
Long Term Care	$942,532.3	$787,949.9	$787,949.9	$787,949.9	$0.0	$787,949.9		$787,949.9
Prescribed Drugs (GRF)	$1,166,225.8	$1,216,514.5	$1,216,514.5		($1,216,514.5)			$0.0
Community Health Centers	$303,372.2	$311,714.6	$311,714.6		($311,714.6)			$0.0
HMO and MCE - Managed Care	$259,319.4	$281,472.5	$281,472.5		($281,472.5)			$0.0
Hospice Care	$80,258.7	$70,983.6	$70,983.6		($70,983.6)			$0.0
Laboratories	$45,459.7	$55,983.6	$55,983.6		($55,983.6)			$0.0

Department of Healthcare and Family Services

FY10 Potential Cut Scenario

$ in 000's

GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Home Health Care	$71,204.3	$69,752.2	$69,752.2		($69,752.2)			$0.0
Appliances	$78,756.0	$76,580.4	$76,580.4		($76,580.4)			$0.0
Transportation	$129,051.9	$109,233.2	$109,233.2		($109,233.2)			$0.0
Other Related Medical	$197,965.4	$229,611.2	$229,611.2		($229,611.2)			$0.0
Medicare Part A Premium	$20,780.3	$20,478.0	$20,478.0		($20,478.0)			$0.0
Medicare Part B Premium	$273,559.7	$293,197.1	$293,197.1		($293,197.1)			$0.0
Medicare Part B Expansion	$18,162.6	$19,890.7	$19,890.7		($19,890.7)			$0.0
Div. of Specialized Care for Children	$69,680.0	$72,467.2	$72,467.2		($72,467.2)			$0.0
Chronic Renal Disease	$2,000.0	$1,359.5	$1,359.5		($1,359.5)			$0.0
Hemophilia	$14,624.2	$12,732.0	$12,732.0		($12,732.0)			$0.0
Sexual Assault Victims	$2,396.6	$2,003.0	$2,003.0		($2,003.0)			$0.0
Child Health Rebate	$8,581.6	$8,231.7	$8,231.7		($8,231.7)			$0.0
Altgeld Clinic	$400.0	$400.0	$400.0		($400.0)			$0.0
Gilead Outreach and Referral Center	$500.0	$0.0	$0.0		$0.0			$0.0
Illinois Cares Rx			($40,000.0)		$0.0	($40,000.0)	$0.0	($40,000.0)
Total GRF	**$9,639,640.7**	**$9,046,129.3**	**$8,996,714.4**	**$6,808,585.7**	**($2,236,039.8)**	**$6,760,674.6**	**$1,000,000.0**	**$7,760,674.6**

Department of Human Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$863,038.2**	**$791,549.4**	**$742,910.3**	**$716,034.4**	**($75,131.8)**	**$667,778.5**	**$0.0**	**$667,778.5**
Other Operations	**$220,115.3**	**$209,207.3**	**$205,627.7**	**$209,207.3**	**($0.3)**	**$205,627.4**	**$0.0**	**$205,627.4**
Lump Sums	**$47,540.1**	**$67,316.6**	**$63,267.0**	**$67,316.6**	**($803.1)**	**$62,463.9**	**$0.0**	**$62,463.9**
HCD								
TANF Reauth Infrastructure	$3,000.0	$2,907.6	$0.6		$0.0	$0.6		$0.6
Admin								
Lincoln Developmental Center Operations	$990.9	$990.9	$248.3		$0.0	$248.3		$248.3
Cornerstone	$774.8	$763.4	$763.4		($76.3)	$687.1		$687.1
Health Insurance Portability & Accountability Act (HIPAA)	$422.6	$409.6	$9.6		$0.0	$9.6		$9.6
Indirect Cost Principles	$3,329.3	$3,226.8	$3,226.8		($226.8)	$3,000.0		$3,000.0
Sexually Violent Persons Program	$1,660.0	$1,868.1	$1,868.1		$0.0	$1,868.1		$1,868.1
ISD Technology	$250.0	$250.0	$250.0		($250.0)	$0.0		$0.0
ISVI Technology	$250.0	$250.0	$250.0		($250.0)	$0.0		$0.0
No Reductions:					$0.0			
Shared Services	$15,341.5	$0.0	$0.0		$0.0	$0.0		$0.0
Refunds	$9.0	$8.7	$8.7		$0.0	$8.7		$8.7
Front Line Staff		$3,490.8	$3,490.8		$0.0	$3,490.8		$3,490.8
Howe Transition	$0.0	$32,382.2	$32,382.2		$0.0	$32,382.2		$32,382.2
Tinley Park Network	$20,900.9	$20,639.2	$20,639.2		$0.0	$20,639.2		$20,639.2
Tort Claims	$580.9	$100.0	$100.0		$0.0	$100.0		$100.0
Work-Related Personal Property Damages	$12.6	$12.2	$12.2		$0.0	$12.2		$12.2
In-Service Training	$17.6	$17.1	$17.1		$0.0	$17.1		$17.1
Grants	**$3,077,417.5**	**$3,253,884.0**	**$3,064,404.2**	**$1,596,859.6**	**($1,467,544.6)**	**$1,596,859.6**	**$1,399,375.0**	**$2,996,234.6**
Mental Health								
MI Grants - Community Based Programs	$228,375.9	$217,086.9	$192,484.6					$180,757.4
Psychotropic Medications	$2,940.0	$2,940.0	$2,646.0					$2,646.0

Department of Human Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Children's Mental Health Partnership	$2,940.0	$2,646.0	$2,381.4					$2,381.4
Metro C&A Community Grants	$36,235.9	$36,235.9	$35,935.9					$33,935.9
MH Transport	$1,176.0	$1,576.0	$1,176.0					$1,176.0
MH Transition	$22,522.9	$22,592.1	$21,592.1					$19,592.1
DRS								
Home Services	$491,789.5	$530,685.0	$502,789.1					$502,789.1
Scandinavian Lekotek Libraries	$569.5	$512.5	$0.0					$0.0
Supported Employment	$2,131.7	$2,131.7	$1,054.6					$1,054.6
SSI Advocacy Services	$2,454.7	$2,381.1	$1,484.0					$1,484.0
Independent Living Centers	$5,022.8	$5,022.8	$5,022.8					$4,520.8
IL Coalition	$112.6	$112.6	$0.0					$0.0
DD								
DD Services	$992,852.9	$1,092,439.7	$1,000,400.8					$970,511.0
Autism Project	$4,900.0	$4,218.5	$3,796.7					$4,900.0
ARC of Illinois Life Span Project	$270.0	$590.0	$531.0					$531.0
DASA								
Addiction Treatment	$43,299.9	$79,699.8	$71,729.8					$60,143.4
Substance Abuse/Domestic Violence Demonstration Project	$641.8	$641.8	$577.6					$548.7
Addiction Treatment DCFS Wards	$12,038.9	$12,038.9	$10,835.0					$9,293.3
Addiction treatment - special pop	$0.0	$9,057.4	$8,151.7					$6,744.1
Welfare Reform Pilot (Addict Treat)	$0.0	$2,787.2	$2,508.2					$1,961.2
HCD								
Childcare Services	$641,200.5	$641,200.5	$641,200.5					$641,200.5
TANF	$98,115.0	$99,297.5	$99,297.5					$93,297.5
Funeral & Burial	$9,150.7	$12,581.2	$9,150.7					$12,581.2
Transitional Assistance	$11,000.0	$11,000.0	$2,000.0					$5,200.0
Food Stamp, Employment & Training	$10,642.2	$10,314.4	$10,314.4					$9,000.0
Immigrant Integration Services (New Americans & Welcoming Centers)	$5,165.3	$9,997.6	$8,997.8					$8,997.8
Homeless Shelter (Emergency Food &)	$9,413.9	$9,124.0	$8,211.6					$9,123.6

Department of Human Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Refugees	$1,575.7	$1,575.7	$1,418.1					$2,218.1
SFCA	$1,339.0	$1,339.0	$1,205.1					$1,455.1
Childrens Place	$752.7	$729.5	$656.6					$656.6
Refugee Social Services	$541.0	$524.3	$471.9					$471.9
Crisis Nurseries	$487.1	$472.1	$424.9					$424.9
Assets for Independence	$250.0	$242.3	$218.1					$218.1
Food Pantries	$0.0	$1,000.0	$0.0					$0.0
Employability Development	$20,701.8	$20,064.2	$18,057.8					$17,691.7
Housing Development	$0.0	$2,000.0	$1,800.0					$1,710.0
Great START	$0.0	$1,891.4	$1,702.3					$0.0
Homelessness Prevention	$0.0	$11,000.0	$9,900.0					$2,400.0
CHP								
Addiction Prevention & Related Services	$6,118.6	$5,282.8	$4,754.5					$4,754.5
Meth Awareness	$1,500.0	$1,331.2	$1,198.1					$1,198.1
Rape Prevention - ICASA	$5,810.8	$5,229.8	$4,706.8					$4,706.8
Teen REACH (Youth Programs)	$18,732.5	$17,460.4	$15,714.4					$15,714.4
Contraceptives (Family Planning)	$965.8	$839.8	$755.8					$755.8
Domestic Violence Shelters & Svcs.	$21,591.0	$21,591.0	$19,431.9					$19,431.9
Intensive Prenatal Performance Project	$5,047.0	$4,761.7	$4,285.5					$4,285.5
Supportive Housing Services	$3,490.3	$3,382.8	$3,044.5					$3,382.5
Teen Parent Services	$7,020.6	$6,661.7	$5,995.5					$5,995.5
Healthy Families	$11,247.8	$10,123.0	$10,123.0					$10,123.0
Community Youth Services	$6,853.7	$5,960.2	$5,364.2					$5,364.2
Comprehensive Community Based Youth Svcs. (CCBYS)	$12,756.9	$11,095.9	$9,986.3					$9,986.3
Unified Delinquency Intervention Svcs. (UDIS)	$3,019.2	$2,620.9	$2,358.8					$2,358.8
Delinquency Prevention	$1,547.7	$1,343.4	$1,209.1					$1,209.1
Comm's For Youth - Youth Service programs associated w/JJ Reform	$3,696.1	$3,220.7	$2,898.6					$2,898.6
Redeploy Illinois	$3,229.1	$3,129.6	$2,816.6					$2,816.6
Early Intervention	$79,077.2	$76,709.0	$76,709.0					$76,709.0

Department of Human Services
FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Juvenile Intervention Services Center	$588.0	$511.1	$0.0					$0.0
Homeless Youth Services	$4,652.7	$4,024.4	$3,622.0					$3,622.0
Parents Too Soon	$7,710.8	$6,939.7	$6,939.7					$6,939.7
No Reductions								
AABD	$28,000.0	$29,214.5	$29,214.5					$29,214.5
Medicaid Treatment - Addictions	$52,234.9	$57,234.9	$57,234.9					$57,234.9
Family Case Management-Indigent (Infant Mortality)	$44,725.9	$43,384.6	$43,384.6					$43,384.6
POC for C & A with MI (ICG)	$27,550.5	$27,550.5	$27,550.5					$27,550.5
DD Community Transitions	$7,791.0	$23,480.2	$23,480.2					$23,480.2
Case Services	$9,513.3	$9,513.3	$9,513.3					$9,513.3
DD Special Services	$8,647.9	$8,161.4	$8,161.4					$8,161.4
DCFS CILA Transition	$6,382.5	$2,288.1	$2,288.1					$2,288.1
DD Waiver Quality Assurance	$500.3	$490.2	$490.2					$490.2
USDA Commodity (Emergency Food)	$253.6	$245.8	$245.8					$245.8
Living Skills	$200.3	$189.2	$189.2					$189.2
Independent Living - Old/Blind	$142.6	$142.6	$142.6					$142.6
Case Services to Migrant Workers	$20.0	$20.0	$20.0					$20.0
Immigrant Services (Nutritional Services for non-citizens)	$5,150.0	$0.0	$0.0					$0.0
MI Supportive Housing	$13,965.0	$0.0	$0.0					$0.0
Farm Resource Center	$245.0	$0.0	$0.0					$0.0
Lewis & Clark Community College	$215.6	$0.0	$0.0					$0.0
Chicago Area Project	$1,960.0	$0.0	$0.0					$0.0
SD Lump reapprop	$2,903.4	$0.0	$0.0					$0.0
Best Buddies	$500.0	$0.0	$450.0					$450.0
Chicagoland Memory Bridge	$750.0	$0.0	$0.0					$0.0
IL Coalition of Community SVCS	$500.0	$0.0	$0.0					$0.0
Permanent Improvements	**$750.0**	**$3,669.7**	**$1,669.7**	**$3,669.7**	**$0.0**	**$1,669.7**	**$0.0**	**$1,669.7**
Total GRF	**$4,208,861.0**	**$4,325,627.0**	**$4,077,878.9**	**$2,593,087.6**	**($1,543,479.8)**	**$2,534,399.1**	**$1,399,375.0**	**$3,933,774.1**

Department of Juvenile Justice

FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$99,400.4**	**$89,151.9**	**$87,150.1**	**$87,755.2**	**($3,868.3)**	**$83,281.8**	**$0.0**	**$83,281.8**
Furlough Days for all 400 non-frontline staff						($1,246.1)	0.0	($1,246.1)
Facility Restructuring savings						($5,091.0)		($5,091.0)
Budget Shortfall associated w/Bargaining Unit Lump sum						$1,863.7		$1,863.7
Other Operations & Contracts	**$26,304.9**	**$35,148.5**	**$29,530.8**	**$27,115.0**	**($3,549.7)**	**$25,981.1**	**$0.0**	**$25,981.1**
Facility Restructuring						($1,630.8)	0.0	($1,630.8)
Budget Shortfall associated w/Operational Exp. Lump sum						$496.9	0.0	$496.9
Lump Sums & Grants	**$666.1**	**$406.5**	**$280.2**	**$293.1**	**$12.9**	**$293.1**	**$0.0**	**$293.1**
Reserve Tort Claims, Sheriff's Fees, SA Reimbursement						($126.3)		($126.3)
Reduce R&M Spending by $6.0k						($6.0)		($6.0)
Budget Shortfall associated w/Grants and Other Ops Unit Lump sum						$132.3		$132.3
Total GRF	**$126,371.4**	**$124,706.9**	**$116,961.1**	**$115,163.3**	**($7,405.1)**	**$109,556.0**	**$0.0**	**$109,556.0**

Department of Public Health

FY10 Enacted and Management Plan

$ in 000's

GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$44,096.5**	**$46,586.9**	**$42,283.7**	**$42,143.2**	**($4,584.2)**	**$37,699.5**	**$0.0**	**$37,699.5**
Other Operations	**$12,253.6**	**$12,252.4**	**$12,252.4**	**$12,252.4**	**$0.0**	**$12,252.4**	**$0.0**	**$12,252.4**
Lump Sums	**$57,815.3**	**$53,873.6**	**$49,456.4**	**$26,936.8**	**($30,610.5)**	**$18,845.9**	**$33,262.2**	**$52,108.1**
Breast & Cervical Cancer-Ctr for Min. Hlth	$4,000.0	$4,000.0	$3,600.0			$0.0	$4,000.0	$4,000.0
Exp. Computer Equip for PH Info Network	$67.8	$65.8	$59.2			$59.2	$0.0	$59.2
Adoption Registry & Medical Info. Exch.	$156.2	$156.2	$140.6			$140.6	$0.0	$140.6
Maintain Computer Vital Records System	$219.5	$212.9	$191.6			$191.6	$0.0	$191.6
Expenses of Regional Database	$29.2	$28.3	$25.5			$25.5	$0.0	$25.5
Shared Services	$2,699.8	$0.0	$0.0			$0.0	$0.0	$0.0
Public Health Prevention Systems	$852.1	$826.5	$743.9			$743.9	$0.0	$743.9
Children's Immunizations (TOTS)	$234.0	$227.0	$204.3			$204.3	$0.0	$204.3
Health Screening Programs	$130.1	$126.2	$113.6			$113.6	$0.0	$113.6
Prostate Cancer Screening and Awareness	$297.0	$297.0	$267.3			$0.0	$297.0	$297.0
Prostate Cancer Public Awareness Initiative	$1,200.0	$1,200.0	$1,080.0			$0.0	$1,200.0	$1,200.0
Sudden Infant Death Syndrome (SIDS)	$250.0	$250.0	$225.0			$0.0	$250.0	$250.0
Bridget Hartigan Education and Awareness Campaign	$100.0	$97.0	$87.3			$0.0	$0.0	$0.0
Suicide Prevention	$350.0	$339.5	$305.6			$0.0	$0.0	$0.0
Newborn Hearing	$0.0	$0.0	$0.0			$0.0	$0.0	$0.0
Assisted Living and Shared Housing Program	$241.8	$241.8	$217.6			$217.6	$0.0	$217.6
Integrated Pest Management Program	$193.0	$187.2	$168.5			$0.0	$0.0	$0.0
Rapid Response Team	$586.2	$568.6	$511.7			$511.7	$0.0	$511.7
Env Health Investigation - Mercury	$496.3	$481.4	$433.3			$433.3	$0.0	$433.3
Homeland Security - lab capacity & statewide communication	$521.2	$505.6	$455.0			$455.0	$0.0	$455.0
Lead Poisoning Screening, Prev. and Abate.	$1,672.0	$1,621.8	$1,459.6			$1,200.0	$0.0	$1,200.0
AIDS Hotline	$355.0	$355.0	$319.5			$355.0	$0.0	$355.0

Department of Public Health

FY10 Enacted and Management Plan

$ in 000's

GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
AIDS CTRPN, Ed, Serv., Pt.& Empler Notify.	$19,001.2	$18,431.2	$18,431.2			$7,000.0	$11,431.2	$18,431.2
Minority AIDS/HIV Prevention & Outreach	$3,150.0	$3,150.0	$2,835.0			$0.0	$3,150.0	$3,150.0
HIV/Correctional Facilities	$2,000.0	$1,940.0	$873.0			$0.0	$1,940.0	$1,940.0
Task Force on Health Planning Reform	$250.0	$0.0	$0.0			$0.0	$0.0	$0.0
Rapid Response Team - Lab	$112.3	$108.9	$98.0			$0.0	$0.0	$0.0
Chicago Lab Consolidation Expenses	$3,824.4	$3,824.4	$3,442.0			$3,442.0	$0.0	$3,442.0
Breast and Cervical Cancer Program	$11,000.0	$11,000.0	$9,900.0			$2,000.0	$9,000.0	$11,000.0
Women's Health Promotion programs	$927.7	$899.9	$809.9			$0.0	$1,994.0	$1,994.0
Women's Healthline	$86.4	$86.4	$77.8			$0.0	$0.0	$0.0
Op. of Breast Cancer	$25.1	$24.3	$21.9			$0.0	$0.0	$0.0
Breast Cancer Fund	$200.0	$100.0	$90.0			$0.0	$0.0	$0.0
Adverse Pregnancy Outcome Reporting System	$378.6	$378.6	$340.7			$340.7	$0.0	$340.7
Matching Funds for National Cancer Institute	$183.2	$177.7	$159.9			$159.9	$0.0	$159.9
Scholarships to Allied Health Professionals	$91.1	$88.4	$79.6			$0.0	$0.0	$0.0
Expenses for Hospital Assessment Act (PA 94-242)	$972.4	$943.2	$848.9			$848.9	$0.0	$848.9
Center for Rural Health	$461.7	$447.8	$403.0			$403.1	$0.0	$403.1
Electronic Health Records	$500.0	$485.0	$436.5			$0.0	$0.0	$0.0
Grants	**$46,256.3**	**$37,582.6**	**$34,069.3**	**$18,791.3**	**($7,187.1)**	**$26,882.2**	**$6,379.9**	**$33,262.1**
Medical Scholarships Grant to BHE	$2,475.0	$1,500.0	$1,500.0			$1,500.0	$0.0	$1,500.0
Developmental Local Health Departments	$127.7	$123.9	$111.5			$0.0	$0.0	$0.0
Perinatal Services for Premature and High Risk	$1,136.9	$1,136.9	$1,023.2			$1,136.9	$0.0	$1,136.9
Children's Memorial Hospital (Violent Death)	$200.0	$194.0	$174.6			$174.0	$0.0	$174.0
Farm Resource Center	$465.6	$419.0	$377.1			$0.0	$0.0	$0.0
Donated Dental Services	$72.0	$72.0	$64.8			$0.0	$0.0	$0.0
Direct Care Perinatal Services	$1,000.0	$1,000.0	$900.0			$0.0	$0.0	$0.0

Department of Public Health

FY10 Enacted and Management Plan

$ in 000's

GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Suburban Primary Health Care Council	$3,000.0	$0.0	$0.0			$0.0	$0.0	$0.0
University of Chicago Transplant Section-Juvenile Diabetes Research	$2,500.0	$1,250.0	$1,125.0			$0.0	$0.0	$0.0
Vision and Hearing Screening	$662.7	$662.7	$596.4			$662.0	$0.0	$662.0
IL College of Optometry	$20.0	$20.0	$18.0			$0.0	$0.0	$0.0
ALS - Lou Gehrig's Disease	$0.0	$0.0	$0.0			$0.0	$1,000.0	$1,000.0
Dental Loan Repayment Program	$50.0	$48.5	$43.7			$0.0	$0.0	$0.0
Immunizations and Outreach Activities	$4,763.1	$4,763.1	$4,286.8			$1,276.3	$3,484.8	$4,761.1
STD medical services	$10.6	$10.3	$9.3			$0.0	$0.0	$0.0
Local Health Protection Grants	$17,098.5	$17,098.5	$15,388.7			$17,098.5	$0.0	$17,098.5
Uofl MC in Chgo Sickle-Cell Clinic	$600.0	$300.0	$0.0			$0.0	$0.0	$0.0
Women's Health promotion	$1,127.9	$1,094.1	$984.7			$0.0	$0.0	$0.0
Ovarian Cancer Research	$100.0	$50.0	$0.0			$0.0	$0.0	$0.0
Residency Programs pursuant to Family Practice Residency Act	$776.0	$752.7	$677.4			$0.0	$752.7	$752.7
Matching Grants--Comprehensive Primary Care	$392.6	$380.8	$342.7			$0.0	$380.8	$380.8
Community and Migrant Health Centers	$392.6	$380.8	$342.7			$0.0	$380.8	$380.8
Hospital Grants--Diversify and relief for Acute Care Bed capacity	$392.6	$380.8	$342.7			$0.0	$380.8	$380.8
Community Health Center Expansion	$6,991.0	$4,100.0	$4,100.0			$3,690.0	$0.0	$3,690.0
Poison Control Center	$1,901.5	$1,844.5	$1,660.1			$1,344.5	$0.0	$1,344.5
Total GRF	**$160,421.7**	**$150,295.5**	**$138,061.8**	**$100,123.7**	**($42,381.8)**	**$95,680.0**	**$39,642.1**	**$135,322.1**

Department on Aging

FY10 Enacted and Management Plan
$ in 000's
GRF Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$4,018.3**	**$6,234.0**	**$5,635.7**	**$5,639.2**	**($537.7)**	**$5,098.0**	**$0.0**	**$5,098.0**
								$0.0
Other Operations	**$781.4**	**$2,108.9**	**781.4**	**2,108.9**	**1,319.5**	**2,108.9**	**0.0**	**$2,100.9**
Lump Sums & Grants	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**
								$0.0
Grants	**$533,736.2**	**$694,646.7**	**$667,534.3**	**$306,473.4**	**($361,060.9)**	**$306,473.5**	**$342,000.0**	**$648,473.5**
CCP Program	$413,413.0	$572,067.2	$572,067.2		$0.0	$211,006.4	342,000.0	$553,006.4
Retired Senior Volunteer Program	$782.0	$782.0	$703.8		$0.0	$703.8	0.0	$703.8
Planning and Services Grants to Area Agencies	$2,241.7	$2,241.7	2,241.7		$0.0	$2,241.7	0.0	$2,241.7
Foster Grandparent Program	$342.1	$342.1	307.9		$0.0	$307.9	0.0	$307.9
Exp to Agencies for LTC Systems Development	$276.0	$276.0	$248.4		$0.0	$248.4	0.0	$248.4
Red-Tape Cutters (SAAA)	$251.7	$0.0	$0.0		$0.0	$0.0	0.0	$0.0
Ombudsman Program	$391.0	$391.0	$351.9		$0.0	$351.9	0.0	$351.9
HDM and Mobile Food Equipment	$7,969.6	$7,969.6	$7,172.6		$0.0	$7,172.6	0.0	$7,172.6
Red-Tape Cutters (Chicago)	$603.6	$0.0	$0.0		$0.0	$0.0	0.0	$0.0
Community Based Services (info, refer, trans)	$3,062.3	$3,062.3	$3,062.3		$0.0	$3,062.3	0.0	$3,062.3
Community Based Services (equal distribution)	$1,955.0	$1,955.0	$1,955.0		$0.0	$1,955.0	0.0	$1,955.0
CCC - Case Management	$43,428.6	$45,428.6	$40,885.7		$0.0	$40,885.7	0.0	$40,885.7
Exp of Elder Abuse and Neglect Program	$10,041.4	$11,042.0	$9,937.8		$0.0	$9,937.8	0.0	$9,937.8
Circuit Breaker/Pharmaceutical Assistance	$44,196.0	$44,196.0	$24,196.0		$0.0	$24,196.0	0.0	$24,196.0
Exp of Senior Employment Program	$264.3	$264.3	$237.9		$0.0	$237.9	0.0	$237.9
Older Adult Initiatives	$0.0	$10.0	$9.0		$0.0	$9.0	0.0	$9.0
Exp of Intergenerational Programs	$60.9	$60.9	$54.8		$0.0	$54.8	0.0	$54.8
Grandparents Raising Grandchildren	$336.5	$336.5	$302.9		$0.0	$302.9	0.0	$302.9
Home Delivered Meals Distribution and Mobile Food Equipment	$2,000.0	$2,000.0	$1,800.0		$0.0	$1,800.0	0.0	$1,800.0
Alzheimer's Initiative and Related Programs	$104.7	$104.7	$94.2		$0.0	$94.2	0.0	$94.2
Exp for Monitoring and Support Services	$296.9	$296.9	267.2		$0.0	$267.2	0.0	$267.2
Exp of Illinois Council on Aging	$12.2	$20.0	18.0		$0.0	$18.0	0.0	$18.0
Exp of Senior Meal Program	$34.5	$34.5	$31.1		$0.0	$31.1	0.0	$31.1
Alzheimer's Task Force	$12.4	$12.4	$11.2		$0.0	$11.2	0.0	$11.2
Exp of Senior Helpline	$1,650.0	$1,753.0	$1,577.7		$0.0	$1,577.7	0.0	$1,577.7
Exp of Red-Tape Cutters Program	$9.8	$0.0	$0.0		$0.0	$0.0	0.0	$0.0
Total GRF	**$538,535.9**	**$702,981.6**	**$673,951.4**	**$314,213.5**	**($360,279.0)**	**$313,672.4**	**$342,000.0**	**$655,672.4**

Illinois State Board of Education

FY10 Enacted and Management Plan

$ in 000's

General Funds Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Personal Services & Related	**$17,375.8**	**$21,486.0**	**$19,405.7**	**$18,395.2**	**($796.6)**	**$18,609.1**	**$0.0**	**$18,609.1**
Other Operations	**$6,874.7**	**$7,940.4**	**$7,940.4**	**$0.0**	**$0.0**	**$7,940.4**	**$0.0**	**$7,940.4**
Lump Sums	**$33,602.0**	**$43,479.2**	**$33,602.0**	**$41,756.3**	**$213.9**	**$33,815.9**	**$0.0**	**$33,815.9**
Student Assessments - Including Bilingual	$29,982.0	$32,514.2	$29,982.0		($1,375.2)	$28,606.8		$28,606.8
Response to Intervention Initiative	$2,000.0	$2,000.0	$2,000.0		($660.0)	$1,340.0		$1,340.0
Longitudinal Data System	$0.0	$2,000.0	$0.0		$250.0	$250.0		$250.0
American Diploma Project	$0.0	$2,000.0	$0.0		$500.0	$500.0		$500.0
Regional Super Services - Bus Driver Training	$70.0	$70.0	$70.0		$0.0	$70.0		$70.0
Community Residential Services Authority	$575.0	$600.0	$575.0		$0.0	$575.0		$575.0
Educator Misconduct Investigations	$375.0	$495.0	$375.0		$0.0	$375.0		$375.0
Strategic Plan	$500.0	$500.0	$500.0		($250.0)	$250.0		$250.0
On-line Database	$0.0	$2,500.0	$0.0		$0.0	$0.0		$0.0
Regional Super & Asst. Compensation	$0.0	$0.0	$0.0		$1,749.1	$1,749.1		$1,749.1
Deposit - Temp Relocation Exp RV GR	$100.0	$800.0	$100.0		$0.0	$100.0		$100.0
Grants	**$7,386,559.9**	**$7,554,348.5**	**$7,391,781.9**	**$7,097,055.3**	**($294,940.6)**	**$7,096,841.4**	**$150,670.5**	**$7,247,511.9**
GENERAL STATE AID	$3,542,574.0	$3,809,529.4	$3,806,305.0	$3,809,529.4	$3,224.4	$3,809,529.4		$3,809,529.4
GENERAL ST AID-HOLD HARMLESS	$26,106.4	$15,670.6	$18,370.9	$15,670.6	($2,700.3)	$15,670.6		$15,670.6
SFSF Education - GSA	$1,038,987.6	$601,717.2	$601,717.2	$601,717.2	($0.0)	$601,717.2		$601,717.2
SFSF General - GSA	$0.0	$295,743.8	$192,282.8	$189,058.5	($3,224.3)	$189,058.5		$189,058.5
Sp Ed - Summer School	$11,000.0	$11,700.0	$11,700.0	$11,700.0	$0.0	$11,700.0		$11,700.0
Free Breakfast/Lunch Program	$26,300.0	$26,300.0	$26,300.0	$26,300.0	$0.0	$26,300.0		$26,300.0
Orphanage Tuition	$11,600.0	$13,000.0	$13,000.0	$13,000.0	$0.0	$13,000.0		$13,000.0
Sp Ed - Orphanage Tuition	$101,800.0	$120,200.0	$120,200.0	$120,200.0	$0.0	$120,200.0		$120,200.0
Sp Ed - Private Tuition	$151,600.0	$181,100.0	$181,100.0	$181,100.0	$0.0	$181,100.0		$181,100.0

Illinois State Board of Education

FY10 Enacted and Management Plan

$ in 000's

General Funds Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Transportation Regular/Vocational	$339,500.0	$351,100.0	$351,100.0	$351,100.0	$0.0	$351,100.0		$351,100.0
Sp Ed - For Children Req. Sp. Ed. Serv.	$331,051.1	$334,236.8	$334,236.8	$334,236.8	$0.0	$334,236.8		$334,236.8
Sp Ed - Transportation	$383,300.0	$429,700.0	$429,700.0	$429,700.0	$0.0	$429,700.0		$429,700.0
Sp Ed - Personnel Reimbursement	$426,100.0	$459,600.0	$459,600.0	$459,600.0	$0.0	$459,600.0		$459,600.0
Awards & Grants LS SB 1216				$364,755.4				
SFSF General - Ed Purp LS SB 1216				$146,560.9				
Statewide System of Support	$3,342.7	$4,842.7	$3,342.7		($1,671.3)	$1,671.4		$1,671.4
National Board Certified Teachers	$11,485.0	$11,485.0	$11,485.0		($5,742.5)	$5,742.5		$5,742.5
Teacher/Admin Mentoring/Induction Prog.	$14,000.0	$14,000.0	$14,000.0		($4,620.0)	$9,380.0		$9,380.0
Grow Your Own Teachers	$3,500.0	$3,500.0	$3,500.0		($1,750.0)	$1,750.0	$1,400.0	$3,150.0
Early Childhood Education	$380,261.4	$392,761.4	$380,261.4		($123,333.4)	$256,928.0	$85,307.3	$342,235.3
SFSF General - Early Childhood					$0.0			$0.0
Regional Superintendent Services	$6,318.0	$6,818.0	$6,318.0		($2,084.9)	$4,233.1		$4,233.1
Regional Superintendents Services	$102.0	$102.0	$102.0		($102.0)	$0.0		$0.0
Regional Super & Asst. Compensation	$9,100.0	$9,919.0	$9,919.0		($1,749.1)	$8,169.9		$8,169.9
Regional Superintendents - Early Retirement Option	$0.0	$400.0	$400.0		($400.0)	$0.0		$0.0
Philip J Rock Center & School	$3,577.8	$3,577.8	$3,577.8		$0.0	$3,577.8		$3,577.8
Textbook Loans	$42,826.5	$42,826.5	$0.0		$0.0	$0.0		$0.0
Textbook Loan Reapprop	$42,826.5	$42,826.5	$42,826.5	$42,826.5	$0.0	$42,826.5		$42,826.5
Tax-Equivalent Grants	$222.6	$222.6	$222.6		($222.6)	$0.0	$222.6	$222.6
District Consolidation Costs	$7,850.0	$3,700.0	$3,700.0		$0.0	$3,700.0		$3,700.0
Principal Mentoring Program	$3,100.0	$2,100.0	$2,100.0		($23.0)	$2,077.0		$2,077.0
Growth Model Assessments	$3,000.0	$3,000.0	$3,000.0		$0.0	$3,000.0		$3,000.0
Re-Enrollment Student Program	$4,000.0	$4,000.0	$4,000.0		($2,000.0)	$2,000.0	$1,600.0	$3,600.0
Truant Alternative & Optional Ed Prg	$20,078.1	$20,078.1	$20,078.1		($10,039.1)	$10,039.0	$8,031.3	$18,070.3
School Breakfast Incentive Prog	$723.5	$723.5	$723.5		($361.7)	$361.8		$361.8
Teacher of the Year	$135.0	$135.0	$135.0		($135.0)	$0.0		$0.0
Summer Bridges Program	$22,238.1	$22,238.1	$22,238.1		($1,522.8)	$20,715.3		$20,715.3
Teach for America	$450.0	$450.0	$450.0		($225.0)	$225.0		$225.0

Illinois State Board of Education

FY10 Enacted and Management Plan

$ in 000's

General Funds Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Autism Training & Technical Assistance	$100.0	$450.0	$100.0		$0.0	$100.0		$100.0
Blind & Dyslexic	$1,218.8	$1,218.8	$1,218.8		($402.2)	$816.6		$816.6
Advanced Placement Classes	$1,646.9	$1,646.9	$1,646.9		($823.4)	$823.5		$823.5
Visually Impaired/Ed Materials Coord	$2,121.0	$2,121.0	$2,121.0		($699.9)	$1,421.1		$1,421.1
Children's Mental Health Partnership	$3,000.0	$3,000.0	$3,000.0		($990.0)	$2,010.0	$690.0	$2,700.0
Agricultural Education Prog	$3,381.2	$3,381.2	$3,381.2		($1,690.6)	$1,690.6	$1,352.5	$3,043.1
Charter Schools - Transition Impact Aid	$3,421.5	$3,421.5	$3,421.5		($3,421.5)	$0.0		$0.0
Arts & Foreign Language	$4,000.0	$4,000.0	$4,000.0		($2,000.0)	$2,000.0		$2,000.0
Technology for Success	$4,169.7	$4,169.7	$4,169.7		$0.0	$4,169.7		$4,169.7
Alternative Ed/Regional Safe Schools	$18,535.5	$18,535.5	$18,535.5		($6,116.7)	$12,418.8	$4,263.2	$16,682.0
Bilingual Education	$75,652.0	$83,557.0	$82,652.0		($25,913.0)	$56,739.0	$11,347.8	$68,086.8
Career and Technical Education	$38,562.1	$38,562.1	$38,562.1		$0.0	$38,562.1		$38,562.1
Schl Safety & Ed Improve Blk Grt (ADA Block Grant)	$74,841.0	$74,841.0	$74,841.0		($56,130.7)	$18,710.3		$18,710.3
Reading Improvement Block Grant	$76,139.8	$76,139.8	$76,139.8		($38,069.9)	$38,069.9	$30,455.9	$68,525.8
Afterschool Matters	$500.0				$0.0		$5,000.0	$5,000.0
Parental Participation Pilot Proj	$100.0				$0.0			$0.0
Regional Superintendent Initiatives	$500.0				$0.0			$0.0
Rural Technology Initiative	$4,000.0				$0.0			$0.0
Targeted Interventions	$4,000.0				$0.0			$0.0
Mentoring & Afterschool Programs	$9,700.0				$0.0			$0.0
Chicago Aerospace Initiative	$920.0				$0.0			$0.0
Metro East Consortium Child Advocacy	$217.1				$0.0			$0.0
Jobs for Illinois Grads	$4,000.0				$0.0			$0.0
IL Governmental Internship Program	$129.9				$0.0			$0.0
Classroom Cubed	$2,000.0				$0.0		$1,000.0	$1,000.0
Tech Immersion Pilot Program	$0.0				$0.0			$0.0
Hard to Staff Schools	$3,000.0				$0.0			$0.0
Transition of Minority Students	$578.8				$0.0			$0.0
Gifted Education	$7,000.0				$0.0			$0.0

Illinois State Board of Education

FY10 Enacted and Management Plan

$ in 000's

General Funds Only

Line Item	FY09	FY10 Governor's Revised Budget	FY10 Governor's Revised Budget w/$1B cuts	FY10 Enacted Budget	Changes from Revised	FY10 Agency Allocation	Governor's Reallocation	FY10 Final Budget
Transportation Reimburse Parents/Guard	$11,954.7				$0.0			$0.0
IL Economic Education Program	$250.0				$0.0			$0.0
Class Size Reduction Pilot Project	$8,000.0				$0.0			$0.0
Healthy Kids/Healthy Minds - Chicago	$3,000.0				$0.0			$0.0
Agudath Israel for School Transportation	$1,200.0				$0.0			$0.0
Transitional Assistance	$36,763.6				$0.0			$0.0
Fast Growth Schools	$7,500.0				$0.0			$0.0
Healthy Kids/Healthy Minds - Cicero & Berwin	$1,000.0				$0.0			$0.0
Chicago Principal & Admin Association	$1,000.0				$0.0			$0.0
Homeless Education	$3,000.0				$0.0			$0.0
Adler Planetarium	$200.0				$0.0			$0.0
Museum of Science & Industry	$200.0				$0.0			$0.0
Total GF	**$7,444,412.4**	**$7,627,254.1**	**$7,452,730.0**	**$7,157,206.8**	**($295,523.3)**	**$7,157,206.8**	**$150,670.5**	**$7,307,877.3**

APPENDIX E: ILLINOIS WORKFORCE DEVELOPMENT PROGRAMS UNDER THE DEPARTMENT OF COMMERCE AND ECONOMIC OPPORTUNITY

The Illinois Department of Commerce and Economic Opportunity (DCEO) oversees a number of programs and activities related to economic development, including business development, entrepreneurship support, community development, and workforce development. DCEO's programs are not described in the main body of this report because DCEO was not included among the state agencies in the Executive Order creating the Human Services Commission. The following description of DCEO's workforce development programs is intended to provide a context for the workforce development programs that are included in the scope of the Human Services Commission, such as the employment programs for seniors administered through the Department on Aging and the employment and training programs for Supplemental Nutrition Assistance Program recipients, described in the Employment chapter of this report.

Overview

The Department of Commerce and Economic Opportunity (DCEO) administers several state and federally funded workforce development programs in Illinois.

Federally-funded workforce development programs administered by DCEO include Workforce Investment Act, Title I (WIA): Adults, Dislocated Workers and Youth. WIA was created in 1998 to replace the Job Training Partnership Act and was authorized with five goals:

- Streamlining services through a One Stop system involving mandated partners
- Providing universal services to all job seekers, workers and employers
- Promoting customer choice through the use of vouchers and consumer report card on the performance of training providers
- Strengthening accountability by implementing stricter and longer-term performance measures
- Promoting leadership by the business sector through involvement on the state and local Workforce Investment Boards (WIBs)

The WIA program provides services under three categories: core, intensive and training. Under federal law, there are a number of services that fall under each category and actual services reflect local needs as identified by each local Workforce Investment Boards (WIB).

Since 2003, Illinois has taken major steps to link economic and workforce development starting with the Critical Skill Shortages Initiative (CSSI) and related interagency efforts that focus on critical sectors or career clusters. DCEO is currently working with the Illinois Community College Board, the Illinois State Board of Education, and other partners to develop career pathways based on programs of study in all critical sectors or career clusters including healthcare, manufacturing, transportation and logistics, information technology, and agriculture.

In addition, DCEO has been working with various partners to provide opportunities for adults that are either low-skilled or those with disabilities. Working with the Illinois Community College Board through Shifting Gears, DCEO is partnering to expand access to career pathways for low-skilled adults through sector-based bridge programs and has encouraged local workforce investment areas to expand access to these programs. DCEO has worked with the ISBE and other agency and industry partners to expand access among disadvantaged youth to these pathways through the Illinois Race To The Top (RTTT) initiative. Through **disabilityworks,** qualified people with disabilities are connected with employers or

are connected to service providers and educational institutions to receive additional job skills and training to get a job.

Key state-funded workforce development programs administered by DCEO include the following:

Job Training and Economic Development grant program (JTED): The Job Training and Economic Development (JTED) Grant program assists low-wage/low-skill workers to advance in their careers and helps unemployed or disadvantaged people learn skills necessary to secure employment.

Employment Opportunity Grant Program (EOGP): EOGP was created in 2007 to help address the persistent problem of under-representation of women and people of color in the construction trades. The Chicago-area construction trades unions and community- and faith-based organizations came together to agree upon the establishment of an infrastructure of training programs that would help individuals from underrepresented populations (i.e., women, minorities), and from communities suffering high levels of economic distress, prepare for union apprenticeship programs and careers in jobs as carpenters, electricians, cement masons and other trades.

The EOGP program was designed to bring government agencies that fund public works projects, contractors that complete those projects, unions and training providers together to the same table as a "consortium." For the first time stakeholders would work together to accomplish the EOGP program goals. Four key groups of stakeholders were to be represented in the consortium:

- *Government agencies* funding capital investments in infrastructure and buildings;
- *Building trades unions* representing thousands of Chicago-area tradesmen and women, and operating apprenticeship programs;
- *Construction contractors*, especially those competing for public-sector construction contracts; and
- *Training providers* to recruit and prepare individuals for the construction trades.

Each stakeholder has a role in making the EOGP work: Training providers recruit a diverse jobseeker population and provide them with high-quality instruction and supportive services to ensure that they are qualified for job opportunities; government agencies prioritize diversity goals on public infrastructure projects; unions work with training providers to ensure that curricula match the skills required for apprenticeship examinations; and contractors work with providers to communicate hiring needs and fulfill hiring goals.

Employer Training and Investment Program (ETIP): ETIP grants reimburse new or expanding companies for up to 50 percent of the cost of training their employees. Employers select workers to participate in the training and trainees must be employed by the company.

Population Served

In general, the populations that rely on the publicly-funded workforce development system include: individuals that are chronically unemployed and struggle to get jobs on their own; individuals that are low-income and don't have resources to pay for training; individuals who have not been successful in traditional educational settings; and individuals who are getting services from a related public system: UI, TANF, Food Stamps.

Specific program eligibility includes:

- WIA: provides education and training services to eligible low-income adults, dislocated workers and disadvantaged youth. In addition, WIA provides businesses with a supply of skilled workers to meet their workforce needs: any job seeker and any business (a "universal customer"), JTED: Low-income unemployed and incumbent workers.
- EOGP: women and minorities
- ETIP: Incumbent workers in identified businesses.

A recently released summary of individual-level data for WIA programs across the country showed that Illinois had approximately 13,400 "program exiters"[227] across all programs between April 2008 and March 2009 (the most recent data for a one year period)[228]: 4,588 Adults; 5,252 Dislocated Workers; 3,569 Youth.[229] "Program exiters" refers to the individuals that completed participation in a WIA service in that year. Approximately 50% of all program exiters in the adult program and in the dislocated worker program received some kind of training service.[230]

In FY 2008, the JTED program funded 24 projects using a combination of state general revenue funds and federal WIA discretionary funds. A total of over 900 individuals were expected to be enrolled with a goal of over 575 individuals placed and retained in employment.[231]

Service Delivery System

Services under the federal WIA program are administered locally by administrative entities in 26 LWIAs that cover the state. Some of the administrative entities are local government entities (counties or municipalities) and some are local non-profits. The federal funding goes first to DCEO and then allocations are made to LWIAs based on an existing formula (that takes unemployment and other demographic data factors into account). Some local WIA administrators subcontract with community-based organizations to provide services. Training that is paid for with WIA funding is provided by certified training providers, including community colleges, proprietary schools and non-profit training entities. Partnerships amongst organizations are allowed and often encouraged when the state has discretion to set priorities for funding.

WIA establishes three basic levels of employment and training services to eligible individuals. All adults, age 18 or older, are eligible to receive "core services". These services include: intake and orientation; eligibility determination for WIA and other programs; initial assessment of skills, abilities and needs; access to job vacancy listings; information on the availability of supportive services; and job search and placement assistance. Additional "intensive services" are available to unemployed individuals who have been unable to obtain jobs through core services and those who are employed but need additional training services to reach self-sufficiency. Types of intensive services are: development of individual employment plan; short-term pre-vocational training (soft skills); individual career counseling; resume preparation; English as a Second Language (ESL) and basic computer literacy".

Training services "are also available for those who meet intensive services eligibility but were unable to find employment through those services. Under state policy, at least 40% of an LWIA's annual adult and

227 "Program exiters" are those individuals that completed their WIA program participation in that year. WIA enrollment happens on an ongoing basis over the course of the year and some individuals may stay engaged in activities for more than one year, so "program exiter" does not refer to the number of individuals that are getting any kind of WIA service during a year.
228 Social Policy Research Associates, PY 2008 WIASRD Data Book-Illinois, February 18, 2010.
229 Ibid,, p. 8. Total numbers amounts to more than the total reported on the chart
230 Ibid., p. 48.
231 DCEO, reported as of 12/4/08.

dislocated worker program expenditures must go toward training costs. The majority of training occurs through an Individual Training Accounts (ITAs). This provides individuals with funding to pay for training at a certified training provider. Other types of training include Bridge Programs (which combine basic educational with occupation-specific skills), on-the-job training, and adult education and literacy activities.

For other workforce programs under DCEO, the service delivery system is structured as follows:

- JTED: Eligible grantees are community-based organizations in partnership with employers
- EOGP: Eligible grantees are community-based organizations that partner with labor organizations and contractors.
- ETIP: Grants are awarded to individual businesses, to original equipment manufacturers sponsoring multi-company training for employees of their Illinois supplier companies, and to intermediary organizations operating multi-company training projects. Training is provided in-house by employees, public educational institutions, private consultants or others training providers.

Services provided include the following:

- JTED: For incumbent workers, providers develop training curricula specific to the skill needs of specific employers appropriate for low-skilled, low-wage employees and recently hired disadvantaged individuals; provide industry-linked skill training to low-wage employees and recently hired disadvantaged individuals; and work cooperatively with local employers to evaluate and refine training programs for recently hired disadvantaged individuals and/or existing low-wage workers that will assist the targeted industries in meeting skill shortages.

  For unemployed individuals, providers assess the employment barriers of local residents who are unemployed disadvantaged persons; work cooperatively with local economic development organizations to identify the unmet skill needs of one or more local industries; work cooperatively with local employers from those industries to design and deliver training programs for disadvantaged persons that will assist the targeted industries in meeting skill shortages; and place program completers into jobs in the targeted industries

- EOGP: Services include: Outreach, recruitment, and assessment activities, including motivational, physical and academic assessments; Career awareness and exploration activities; Drug/Alcohol Testing for entry into and exit from program; Reading and Math preparation; Technical skills training; Workplace readiness training; Case Management; Database Development; Mentoring; Support services: including stipends, childcare, transportation, tools and work clothes, and Apprenticeship-prep programs (a program that may have an arrangement with a union apprenticeship program, but does not guarantee successful completers entry into the apprenticeship training program).

- ETIP: Covers up to 50% of training costs for the following eligible activities:
  - Training programs required to respond to new or changing technologies, processes, product lines, machinery or equipment being introduced in the workplace.
  - Training necessary to implement continuous improvement systems in the workplace, including quality certifications.
  - Training employees in skills necessary to enable the company to establish/maintain or expand into new export markets.
  - Training related to regulatory compliance issues mandated for the workplace.

Funding

Federal WIA funding has decreased over the years and serves fewer job-seekers than it once did. WIA adult funding declined from $950 million in 2002 to $859 million in 2008 (9.5%). Dislocated worker funding decreased from $1.5 billion in 2002 to $1.2 billion in 2008 (23.6%). Youth funding declined from $1.1 billion in 2002 to $850 million in 2008 (24.7%).

For Fiscal Year 2011 (referred to as Program Year 2010 in the federal budget), federal allocations for WIA funding have already been made and include significant decreases:

- Program Year 2010 (July 2010 through June 2011) WIA Title 1 Youth funding allocations for Illinois will decrease by 10% from PY 2009: from $48,384,035 to $43,545,632.[232]
- Program Year 2010 WIA Title 1-Adult funding allocations for Illinois will decrease by 10% from PY 2009 from $44,888,169 to $40,399,352.
- Program Year 2010 WIA Title 1-Dislocated Worker funding allocations for Illinois will decrease by 16% from PY 2009 from $65,561,923 to $54,673,396.

State funding for workforce development programs in DCEO is relatively low. The programs were subject to a 50% reduction in 2009 and external advocacy restored the funding. At this point, it does not appear that EOGP and JTED are slated for cuts in the proposed FY11 budget. Total DCEO funding in the state budget for FY 11 will be affected by substantially lower ARRA funding this year.

[232] Source: Training and Employment Guidance Letter No. 19-09, March 30, 2010, Employment and Training Administration, U.S. Department of Labor. PY 2009 or PY 2010 allocations do NOT include one-time ARRA funding.

APPENDIX F: HISTORICAL MILESTONES IN THE DEVELOPMENT OF HUMAN SERVICES

The following list, while not exhaustive, summarizes many key milestones in the development of Illinois's human services system. It also illustrates the system's complex mix of federal, state and federal-state efforts.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
1847	State	General Assembly authorizes construction of **Illinois' first state-operated mental hospital** ("Illinois Hospital for the Insane" in Jacksonville). First patient admitted in 1851.
1918	Federal	The **Vocational Rehabilitation Act** creates vocational rehabilitation programs for disabled veterans of World War I across the country. In 1920 the services are expanded to the general public under the **Smith-Fess Act**.
1933	State	**Illinois Department of Public Welfare** is authorized to place children outside of the home, creating the basis for the eventual work of Department of Children and Family Services (DCFS).
1935	Federal	**The Social Security Act** creates several key safety net programs, including **Old Age Assistance, Aid to the Blind, Aid to Dependent Children** (later Aid to Families with Dependent Children), and **Unemployment Insurance**.
1939	Federal	**Social Security Survivors' Insurance** implemented.
1940	Federal	**Lanham Act** provides federal grants and loans to public or private agencies for the operation of public works.
1944	Federal	**Servicemen's Readjustment Act ("GI Bill")** provides higher education benefits and home and business loans to millions of returning veterans.
1946	Federal	**National School Lunch Act** implemented.
1950	Federal	**Aid to the Permanently and Totally Disabled** implemented.
1956	Federal	**Social Security Disability Insurance** implemented.
1961	State	**Illinois Department of Mental Health** is established.
1963	State	Originating in the Division of Children's Specialized Services in the Illinois Department of Mental Health, the **Department of Children and Family Services** (DCFS) becomes a separate state agency to regulate most child and family social services in Illinois.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
1964	Federal	Following a pilot program, the **Food Stamp Program** (now Supplemental Nutrition Assistance Program) is permanently established.
1965	Federal	**Medicare** implemented.
	Fed & State	**Medicaid** implemented. Illinois chooses to become a state that has its own income and asset eligibility separate from the Social Security income and asset rules (requires extra administrative process).
	Federal	**Head Start** is implemented through the Office of Economic Opportunity to provide a prekindergarten educational experience to children in poverty. The first Head Start program in Illinois opens in 1966.
	Federal	The **Older Americans Act** establishes the Administration on Aging to administer grants to states to provide a range of nutrition and service programs for older adults.
	Fed & State	Federal Medicaid statute precludes federal matching funds for services for individuals in "**institutions for mental disease**." Children and the elderly were later exempted from this exclusion
1966	Federal	The **Child Nutrition Act** establishes the **School Breakfast Program**.
1967	Federal	Title IV-A of the Social Security Act establishes **WIN Child Care Services** to enable parents receiving Aid to Families with Dependent Children to participate in the **Work Incentive (WIN) Program**.
1969	State	DCFS begins the **Child Care Expansion Program** to make grants to local government and nonprofits to expand existing child care facilities and to encourage development of new facilities.
	State	The **Illinois Child Care Act** defines various child care arrangements and sets minimum licensing and performance standards for each.
	Federal	Older Americans Act Amendments provide grants for model demonstration projects, **Foster Grandparents** and **Retired Senior Volunteer Programs**.
1972	Fed & State	**Supplemental Security Income** replaces **Aid to the Aged, Blind, and Disabled (AABD)**, although AABD supplements still exist in many states, including Illinois.
	Federal	**Title VII** under the **Older Americans Act** is created to authorize funds for a national nutrition program for the elderly.
	Federal	The **Special Supplemental Food Program for Women, Infants and Children** is established as an amendment to the Child Nutrition Act.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
1973	Federal	**Older Americans Act Comprehensive Services Amendments** establish Area Agencies on Aging, authorize grants to local community agencies for multi-purpose senior centers, and create the Community Service Employment grant program for low-income persons age 55 and older.
	Federal	The **Rehabilitation Act** is passed; key components include Title I, which establishes vocational rehabilitation services to help people with disabilities gain employment; and Title V, which prohibits discrimination of people with disabilities and requires reasonable accommodations in a variety of education and employment settings.
	State	The **Department on Aging** became a separate **State Unit on Aging (SUA)**, and the Illinois Act of Aging was Adopted.
1974	Federal	The **Food Stamp Program** begins operating nationwide.
	Federal	The **Child Abuse Prevention and Treatment Act** provides assistance to states in developing child abuse identification and prevention programs.
	State	Illinois Department of Mental Health becomes the **Illinois Department of Mental Health and Developmental Disabilities**.
1975	Federal	Title IV-D of the Social Security Act creates the **Office of Child Support Enforcement** within the Department of Health and Human Services to implement federal oversight. Recipients of AFDC are required to cooperate with the state in establishing paternity and securing support.
	Federal	Title XX of the Social Security Act revises requirements for AFDC social services including child care, and expands eligibility to include low-income families not receiving AFDC. **AFDC Child Care Income Disregard** allows working AFDC parents to deduct child care expenses from their earned income when calculating their monthly grant.
1976	Federal	**Earned Income Tax Credit** implemented.
	Federal	**Child and Dependent Care Tax Credit** is implemented, allowing working families to claim a credit against taxes owed for up to 20% of their expenditures for child care, based on income.
1977	Federal	The **Food Stamp Act reauthorization** institutes several changes to the program, including elimination of the requirement that participants purchase their food stamps (participants would pay an amount commensurate with their normal expenditures for food and receive an amount of food stamps representing an opportunity to obtain a low-cost nutritionally adequate diet).

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
	State	**P3 Program** implemented in Illinois to provide interim assistance for people with disabilities who are waiting for their SSI determination, including access to a medical card and AABD cash.
1978	Federal	**Amendments to the Rehabilitation Act of 1973** add Section VII to the act, which defines Centers for Independent Living for people with disabilities and establishes standards and indicators for their operation.
1979	Fed & State	The Illinois Department on Aging's **Community Care Program** helps senior citizens to remain in their own homes by providing in-home and community-based services, partially funded through a Medicaid waiver.
1980	Federal	The **Adoption Assistance and Child Welfare Act** provides the first Federal subsidies to encourage the adoption of children from the nation's foster care system.
1981	Federal	**Low Income Home Energy Assistance Program** implemented.
1982	Federal	The federal government establishes nine Block Grants, restructuring federal funding of health and human services. Title XX became the **Social Services Block Grant** and was reduced by 23%. The goal was to reduce the size and involvement of the federal government and give more discretion to the states in providing an array of social services.
1982	State	Under the ***Benson v. Blaser* consent decree**, the Community Care Program for the elderly became an entitlement, requiring timely determination of eligibility and provision of services.
1984	Fed & State	The **Victims of Crime Act Fund** is established to provide federal support to state and local programs that assist victims of crime, including domestic violence. The fund is derived from fines and penalties paid by offenders at the federal level and distributed to states through a formula grant.
	Federal	The **Family Violence Prevention and Services Act** is passed by Congress to address public awareness and prevention of family violence and provide services for victims and their dependents. The act provides support for a range of services delivered by community-based domestic violence programs.
1985	State	**Circuit Breaker Pharmaceutical Assistance Program** implemented. Initially coverage limited to drugs for cardiovascular disease. Between 1985 and 2001 eight more disease states were added to the benefit.
1988	Federal	Title IV-A of the Social Security Act establishes the **AFDC Child Care Guarantee**, requiring states to guarantee child care for all AFDC parents

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
		who are working or in education and training programs, beginning October 1990.
1989	Fed & State	Federal legislation requires states to offer **Medicaid coverage** to children under age 6 and pregnant women with family incomes below 133% of FPL.
1990	Federal	The **Americans with Disabilities Act** legislates that all individuals with disabilities have reasonable access to public accommodations.
	Federal	Federal legislation mandates incremental expansion of Medicaid coverage for older children (ages 6 through 18) in families with incomes up to 100% of FPL. Illinois begins expansion in July of 1991.
1991	State	DCFS is required to operate under a consent decree known as the **B.H. Decree**. The decree requires DCFS to promptly identify and provide timely access to medical, mental health and developmental needs of its wards; to ensure that specific services outlined in each child's plan be provided; and to develop sufficient foster homes, specialized foster homes, residential placements and independent living programs to meet the placement needs of its wards.
	Fed & State	Illinois General Assembly authorizes the state's participation in federal Medicaid options (clinic option, rehabilitation option, targeted case management option), which expands reimbursable mental health services.
1992	Fed & State	**Amendments to the Rehabilitation Act of 1973** create Statewide Independent Living Councils, to be appointed by the governor of each state and charged with developing a state plan every three years for independent living services for people with disabilities; monitoring that plan; and carrying out activities to expand independent living services throughout the state.
1994	Federal	The reauthorization of Head Start creates a new initiative, **Early Head Start**, to extend Head Start services to infants, toddlers, and pregnant women and their families, recognizing that the period from birth to three years is critical to health, development and school readiness.
	Federal	**The Violence Against Women Act** (VAWA) creates the first U.S. federal legislation acknowledging domestic violence and sexual assault as crimes, and provides federal resources to encourage community-coordinated responses to combating violence

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
1995	State	**General Assistance** (GA) eliminated; GA medical remains for unemployable categories and Transitional Assistance-GA in City of Chicago only. P3 cash and medical assistance still available for people outside of Chicago.
	Fed & State	**Breast and Cervical Cancer Program** is implemented, providing free mammograms, breast exams, pelvic exams and Pap tests to eligible women.
1996	Federal	Congress passes **Personal Responsibility and Work Opportunity Act**: • Eliminates AFDC program and creates **Temporary Assistance for Needy Families** program that requires development of service plans for each family to promote work to move away from assistance. • Limits receipt of TANF benefits to parents for 60 months (some events toll the counting of 60 months). • Adopts stringent rules regarding provision of TANF, Medicaid, SSI, and Social Security to immigrants; many categories of immigrants are made ineligible for benefits. • Tightens the disability standard for **SSI childhood disability benefits** and mandates review of all children on SSI to apply the stricter standard. • Requires review of all **SSI** child recipients at age 18 and mandates application of adult standard. • De-links **Medicaid** eligibility from TANF eligibility • Folds three AFDC-related child care programs into the Child Care and Development Block Grant. The combined funding stream becomes the **Child Care and Development Fund**. • Requires states to adopt specified administrative enforcement remedies to collect child support and to establish a **statewide central collection and disbursement center** for child support. • Separates Medicaid from cash assistance and grants states separate authority to set their eligibility levels.
	Federal	The **Personal Responsibility and Work Opportunity Act** also enacts major changes to the **Food Stamp Program**, including: • Mandating that states implement electronic benefit transfer systems for food stamps by 2002 • Eliminating most legal immigrants' eligibility for food stamps • Placing a time limit on food stamp receipt for able-bodied adults without dependents who are not working at least 20 hours a week or participating in a work program

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
	Federal	Congress **eliminates substance abuse as a primary disabling condition** from the federal disability standard for SSDI and SSI disability and mandates review of disability applicants receiving disability due to drug and alcohol abuse for possible termination.
1997	Fed & State	**State Children's Health Insurance Program (S-CHIP)** is enacted. States are given three implementation options: Medicaid expansion (M-CHIP), a separate state child health program (S-CHIP), or a combination of the two. Under the S-CHIP option, states have more flexibility in requiring premiums and copayments. S-CHIP is implemented in Illinois in 1998.
	Fed & State	**Illinois Child Care Assistance Program** implemented (concurrently with TANF).
	State	All or parts of seven Illinois human service agencies are consolidated into a single **Illinois Department of Human Services**.
	Federal	The **Adoption and Safe Families Act** provides further measures to encourage adoption and support family stabilization.
1998	Fed & State	**Medicaid expansion (M-CHIP)** covers all children ages 6-18 in families with incomes up to 133% of FPL. Separate state program (S-CHIP) covers children between 133% and 185% of FPL.
	Fed & State	The **Child Support Performance and Incentive Act** enables state child support programs to compete for a capped pool of federal incentive monies based on five key performance elements.
1999	Fed & State	The U.S. Supreme Court ruled in the case ***Olmstead v. L.C. and E.W***. that the "integration mandate" of the Americans with Disabilities Act requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Disabled people segregated in institutions have used it to require states to provide services in the community. Illinois has had the most 'Olmstead' lawsuits to date with six.
2000	State w/ Federal Approval	Illinois enacts the **100% Campaign**, an initiative that increases the medically needy income threshold from 41% of FPL to 70% of FPL.
	Fed & State	Illinois institutes 12-month continuous eligibility for **Medicaid** and **S-CHIP** children, regardless of changes in family income or work status.
	Federal	Older Americans Act Amendments establish the **National Family Caregiver Support Program**.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
	Federal	The reauthorization of the **Violence Against Women Act** creates a legal assistance program for victims and expands the definition of crime to include dating violence and stalking.
2001	State	Eligibility for **Medicaid** for elderly is raised to 85% of FPL under second phase of 100% Campaign.
	State w/ Federal Approval	**Health Benefits for Workers with Disabilities (HBWD)** is implemented, allowing working individuals with disabilities who can meet the federal disability standard to "buy-in" to the state Medicaid program. Income eligibility was originally at 250% of FPL with assets limited to $10,000.
2002	State	Elimination of three-month waiting period for **S-CHIP**.
	State	Eligibility of Medicaid for elderly is raised to 100% of FPL under third phase of the 100% Campaign.
	Fed & State	Under a federal waiver, S-CHIP funds are used to cover parents of Medicaid and S-CHIP children ("**FamilyCare**"). Income eligibility limit is initially set at 49% of FPL.
	Federal	The **reauthorization of the Food Stamp Program** restores eligibility for qualified legal immigrants who have been in the United States at least five years and for children, regardless of how long they have been in the country.
	State w/ Federal Approval	Under a Medicaid 1115 waiver, Illinois obtains federal matching funds for some **Circuit Breaker Rx** costs and launches **SeniorCare,** providing low income elderly (under 200% FPL) with comprehensive coverage for all Medicaid covered drugs. Illinois began claiming matching funds at a rate of 50% for the costs of drugs under SeniorCare.
2003	State	Illinois General Assembly passes the Children's Mental Health Act, which creates the **Illinois Children's Mental Health Partnership** to develop a plan to build a comprehensive, coordinated children's mental health system.
	Fed & State	Income eligibility limit for children in **S-CHIP** is raised to 200% of FPL. Income eligibility limit for **FamilyCare** is raised to 90% of FPL.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
2004	State w/ Federal Approval	State institutes presumptive eligibility for children in **S-CHIP**, which provides temporary coverage while their applications are being processed.
	State w/ Federal Approval	Income eligibility limit for **FamilyCare** is raised to 133% of FPL.
	Fed & State	The federal demonstration waiver, **Illinois Healthy Women**, is implemented, providing coverage of family planning services to women losing medical benefits under the state's medical assistance program.
	State	Pursuant to the Children's Mental Health Act, the **Screening, Assessment and Support Services** program was implemented to provide a coordinated statewide system to serve children and adolescents experiencing a mental health crisis whose care will require public funding from DHFS, DHS or DCFS.
2005	State	Circuit Breaker Pharmaceutical and SeniorCare programs are adjusted to complement Medicare Part D, becoming **Illinois Cares Rx,** which provides medication coverage for persons up to 200% of FPL.
	Federal	The **reauthorization of the Violence Against Women Act** enhances support for criminal and civil justice and community-based responses to violence and develops new focus areas including prevention, services for children and teenagers, and the creation of the first federal funding stream to support rape crisis centers.
2006	Fed & State	Income eligibility limit for **FamilyCare** is raised to 185% of Federal Poverty Level (FPL).
	State	**Disease Management** and **Primary Care Case Management** programs are established under Illinois' medical assistance programs. The programs focus on enhancing care management and improving health outcomes by ensuring access and coordination of medical services.

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
	State	**All Kids** implemented, making Illinois the first state to offer health coverage to all uninsured children.
	State	**FamilyCare** eligibility raised to 185% of FPL.
	State	Income eligibility for **Breast and Cervical Cancer Program** expanded to 250% of FPL and program opened to uninsured persons whose screening was not funded by the program.
	State	**Veterans Care** implemented, providing coverage to uninsured veterans with income at or below the federal Geographic Means Test plus 25%FPL.
	State	**Illinois Division of Mental Health** completes its conversion from a grants-based system of financing community mental health services to a fee-for-service system.
	Federal	**Medicare Part D** coverage begins for outpatient prescription drugs for older adults. States are required to cover part of the costs. Drug coverage for dually eligible people shifts from Medicaid to Medicare.
2007	Federal	Congress **amends the PRWOA** of 1996 to allow additional immigrants to receive public benefits.
	Federal	**Family Opportunity Act** implemented to offer Medicaid eligibility to children with disabilities up to 350% of FPL.
	State	Income eligibility requirement eliminated for **Breast and Cervical Cancer Program,** opening the program to all income levels.
	State	Enrollment for **Illinois Healthy Women** opened to women who were not already enrolled for medical benefits through the state's medical assistance program.
2008	Fed & State	**Health Benefits for Workers with Disabilities** enhancements: Income eligibility is increased from 250 to 350% of FPL; assets disregarded up to $25,000; all retirement accounts are disregarded.
	Federal	The **Food, Conservation, and Energy Act** reaffirms federal commitment to food assistance programs and in an efforts to fight stigma, changes the name of the Food Stamp Program to the **Supplemental Nutrition Assistance Program** (SNAP).
	Federal	The **Fostering Connections to Success and Increasing Adoptions Act** promotes guardianship and adoption of foster children by relatives and

State and Federal Social Service and Public Benefits Programs: Historical Milestones

Year	Primary Responsibility	Description
		extends federal support for youth in the foster care system through age 21.
2009	Fed & State	**FamilyCare** codified in statute at 185% of FPL and expansion population.
	Fed & State	**Children's Health Insurance Program Reauthorization Act** passes.
	State	Elimination of some of DCFS's essential services—including psychological assessments, counseling, assistance to pregnant wards, and foster care respite and support services, including day care—is proposed as part of the state budget resolution process. A judge rules that these cuts would violate the **B.H. Consent Decree**, reversing the decision and keeping the services intact.

APPENDIX G: 2009 FEDERAL POVERTY GUIDELINES

For all states (except Alaska and Hawaii) and for the District of Columbia.

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	$10,830	$11,913	$13,538	$16,245	$18,953	$20,036	$21,660
2	$14,570	$16,027	$18,213	$21,855	$25,498	$26,955	$29,140
3	$18,310	$20,141	$22,888	$27,465	$32,043	$33,874	$36,620
4	$22,050	$24,255	$27,563	$33,075	$38,588	$40,793	$44,100
5	$25,790	$28,369	$32,238	$38,685	$45,133	$47,712	$51,580
6	$29,530	$32,483	$36,913	$44,295	$51,678	$54,631	$59,060
7	$33,270	$36,597	$41,588	$49,905	$58,223	$61,550	$66,540
8	$37,010	$40,711	$46,263	$55,515	$64,768	$68,469	$74,020

For family units with more than 8 members, add $3,740 for each additional person at 100% of poverty; $4,114 at 110 %; $4,375 at 125%; $5,610 at 150%; $6,545 at 175%; $6,919 at 185% and $7,480 at 200% of poverty.

In April 2010, the U.S. Congress took action to keep the 2009 poverty guidelines in effect until at least May 31, 2010. The guidelines had not yet been updated at the time of writing of this report.

Source: U.S. Department of Health and Human Services, http://aspe.hhs.gov/poverty/09extension.shtml

APPENDIX H: RESOURCES AND RECOMMENDED READING

In addition to the sources cited throughout this report, there are several other resources that provide key background information about human services. Additional resources and recommended reading on human services include the following reports and documents.

Center for Tax and Budget Accountability (2010). *Special Report: Illinois State Funding for Human Services in Context*. Available at http://www.ctbaonline.org/New_Folder/Human%20Services/FINAL%20CTBA%20Human%20Services%20Report%202.24.2010.pdf

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Williams v Quinn, court documents, fact sheets and press releases available at http://www.equipforequality.org/news/pressreleases/williamsblagojevichfiles.php

Toni Irving, Co-Chair, Governor's Office
Ngoan Le, Co-Chair, The Chicago Community Trust
Joseph Antolin, Heartland Alliance for Human Needs and Human Rights
Damon Arnold, Illinois Department of Public Health
Sam Balark, AT&T
Denver Bitner, Lutheran Social Services of Illinois
Byron T. Brazier, Apostolic Church of God
Mary Ellen Caron, Chicago Department of Family and Support Services
Rosemary Connelly, Misericordia
Sen. William Delgado, Illinois General Assembly
Eileen Durkin, Neumann Family Services
Art Dykstra, Trinity Services, Inc.
Rep. Sara Feigenholtz, Illinois General Assembly
Kurt Friedenauer, Illinois Department of Juvenile Justice
Pam Heavens, Will-Grundy Center for Independent Living
Julie Hamos, Illinois Department of Healthcare and Family Services
Gary Huelsmann, Catholic Social Services of Southern Illinois
Sen. Mattie Hunter, Illinois General Assembly
Anne Irving, AFSCME Council 31
Marco Jacome, Healthcare Alternatives System
Rep. Naomi Jakobsson, Illinois General Assembly
Shawn Jeffers, Little City Foundation
Charles D. Johnson, Illinois Department on Aging
George Jones, Jr., Ada S. McKinley Community Services, Inc.
Richard L. Jones, Metropolitan Family Services
Mark Klaus, Charleston Transitional Facility
Christopher Koch, Illinois State Board of Education
Maggie Laslo, SEIU Healthcare
Valerie S. Lies, Donors Forum
Rep. David Leitch, Illinois General Assembly
Erwin McEwen, Illinois Department of Children and Family Services
Soo Ji Min, Illinois Caucus for Adolescent Health
Rep. Rosemary Mulligan, Illinois General Assembly
Sen. Carole Pankau, Illinois General Assembly
Maria Pesqueira, Mujeres Latinas en Accion
Greg Pierce, United Power
Michael Randle, Illinois Department of Corrections
Nancy Ronquillo, Children's Home and Aid
Dee Ann Ryan, Vermilion County Mental Health
Kathy Ryg, Voices for Illinois Children
Michelle Saddler, Illinois Department of Human Services
Nancy Shier, Ounce of Prevention Fund
Ray Vazquez, YMCA
Sen. Dave Syverson, Illinois General Assembly
Laura Thrall, United Way of Metropolitan Chicago
Maria Whelan, Illinois Action for Children
David E. Whittaker, Chicago Area Project
B. Diane Williams, Safer Foundation

Council 31 AFSCME

June 18, 2010

Toni Irving & Ngoan Le
Co-Chairs
Governor's Human Service Commission
100 West Randolph Street 16th Floor
Chicago, Illinois 60601

Dear Co-Chairs Le and Irving:

Below are my last comments on "Human Services in Illinois - A Point-In-Time Review of the Current System", based upon the Final Draft presented to us at the HSC meeting on June 8, 2010.

Section: OVERVIEW OF HUMAN SERVICES EVOLUTION AND TRENDS
Page 19
"Uneven treatment of human services providers. Whereas unionized state employees can periodically negotiate salary increases and benefits through their contracts, many nonprofit service providers have not received cost-of-living increases for years. Furthermore, when the state experiences cash flow problem, which has become the norm rather than the exception, state employees can continue to receive salary payments while payments to nonprofit contractors are delayed. This has resulted in nonprofit providers having to secure loans to pay for their employees' wages and incurring further costs because of the interest on the loans. The state's inability to make payments on time has created a great deal of financial stress for many service providers and could result in closure of programs. The Donors Forum's Fair and Accountable: Partnership Principles for a Sustainable Human Services System report reflects an effort underway to find solutions to this problem.3

The paragraph above provides apples to oranges comparisons between state workers and state contractors that are neither factual nor helpful. Does the author propose that the state violate wage and hour laws by not paying its workers timely? And as it addresses the gains made by those with the right to bargain collectively with the state, the author would do better to support unionization of private sector human service workers than to criticize the union advantage.

We propose that the paragraph be changed as it appears below:

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"Weakening the human services infrastructure. Many nonprofit service providers have not received regular cost-of-living increases for years, resulting in reimbursement rates that are below the cost of delivering the contracted service. Service providers must raise private dollars to make up for this payment gap. Furthermore, when the state experiences cash flow problem, which has become the norm rather than the exception, payments to nonprofit contractors are delayed for many months. This creates cash-flow problems for service agencies, which must pay their employees even when state reimbursements are delayed. The state payment delays result in nonprofit providers having to secure loans, incurring further costs because of the interest on the loans. The combination of low state reimbursement rates along with the state's inability to make payments on time has created a great deal of financial stress for many service providers and could result in closure of programs or agencies. The Donors Forum's *Fair and Accountable: Partnership Principles for a Sustainable Human Services System* report reflects an effort underway to find solutions to this problem.3 "

Section: **Mental Health**
Page 164

To most accurately reflect the services provide by state operated mental health centers, we propose the following change:

DHS'S DIVISION OF MENTAL HEALTH (DMH)
DHS-DMH has primary responsibility for public mental health services in Illinois. In FY 09, DMH-funded providers served 166,187 individuals in community settings and DMH served 8,742 individuals in its ~~inpatient facilities~~ state mental health centers, with 10,103 admissions to its short-stay inpatient hospitals and 574 court-ordered admissions to its forensic units. The number of individuals served by DMH funded services dropped by almost 10 percent from FY 08 to FY 09 as a result of funding cuts. In FY10, DMH has budgeted $229 million for state operated inpatient facilities and $388 million for community services. In addition, the DMH budget includes $28 million for a treatment and detention facility for sexually dangerous persons.

Section: **REHABILITATIVE / HABILITATIVE SERVICES**
page 230
The latter part of the second paragraph in the third dot point on page 230 is factually inaccurate, and provides the misleading impression that Illinois can easily solve the problem of underfunding community services by closing State Operated Developmental Centers.

The paragraphs are inaccurate because cost of care in an SODC includes medical services while the cost figures for the other settings do not. Moreover, there is no acknowledgement that the average intensity of need varies by setting, which also affects cost.

The following paragraph should be added as a third paragraph to this bullet:
"However, it cannot be documented that serving a given individual would be cheaper in a different setting. Figures for average costs in SODCs include the cost of medical care, the figures for other settings do not. In addition, there is no adjustment in this cost comparison to show difference in intensity of need (behavior disorders, medical condition, etc.) between the populations residing in different settings. These facts are acknowledged in the "Blueprint for

Redesign," which states, 'There are only limited opportunities in Illinois to shift dollars among services to secure meaningful savings that can be redirected to expanding services and/or addressing problems …' The Blueprint study was commissioned by the Illinois Council on Developmental Disabilities, a strong advocate of deinstitutionalization."

Smith, G., Agosta, J. and Daignault, J.; A Blueprint for System Redesign in Illinois, January 2008.

Page 231-232
The chart on page 232 submitted by the ARC of Illinois purports to illustrate (see fourth paragraph of page 231) "…that the amount of funding to SODCs has increased by 45%, while the funding for community programs has increased 12.5." However, it is not at all clear what the chart references. The chart refers to "% increase" but does not indicate what this is a percentage of: is it total appropriation, average cost per consumer?
We question this because we believe it is incorrect that HCBS spending has increased more slowly than SODC spending. In FY 2003, SODCs were allocated 24% of all funds for DD services, 76% went to HCBS, including private ICF-DDs. In absolute terms, SODCs got $293 million while $953 million went to HCBS (including private ICF-DDs). In FY 2008, 21% of funds for DD services went to SODCs, and in the proposed FY 11 DDD budget, just 17% went to SODCs. So it appears that SODCs are a relatively small and shrinking portion of the DDD budget.

Moreover, Braddock and Hemp (see footnote 177) document that between 2004 and 2006, average per person spending in Illinois SODCs actually declined by 4% (State of the States in DD 2008, p. 55.)

AFSCME heartily agrees that rates paid to community providers are inadequate and have not kept pace with inflation. However, it is factually incorrect to imply that the inadequacy of community funding is linked to increases in SODC funding.

Unless the authors can better identify what the chart purports to show, the chart on page 232 and references to the chart in paragraphs 2, 3 and 4 on page 231 should be removed from the report.

Finally, paragraphs 5 and 6 on page 231, which continue to the top of page 232, take a number of statistics from research by Braddock and Hemp, again with the intent of implying that Illinois can solve its underfunding of community services on the cheap by closing state centers. The statistics cited are highly selective, however. A review of Braddock and Hemp's State of the States in Developmental Disabilities 2008 (again, see footnote 177) makes very clear a point that is missing from the Draft. Specifically, states that rank high in community spending fund services at a rate that is higher, not lower, than Illinois.

We propose that the following paragraphs be added after the first paragraph on page 231. Or, if the authors think that too much space is being devoted to this argument, that paragraphs 5 and 6 on page 231, which continue to the top of page 232, be deleted.

While some advocate that shuttering SODCs is a cost-neutral way to improve funding to community services, a look at other states indicates otherwise. A review of Braddock and Hemp's State of the States in Developmental Disabilities 2008 indicates that states which rank high in community spending fund services at a rate that is higher, not lower, than Illinois. For example, Minnesota is ranked 6th in community spending and 36th in institutional spending. Yet Minnesota's rate of spending (fiscal effort) ($6.91) is more than twice that of Illinois $3.17. If Illinois expended Minnesota's level of fiscal effort on DD services, we would have to increase funding by $1.7 billion annually. (Source: Braddock and Hemp, pp. 58-59.)

It is often pointed out that Indiana has done away with all SODCs. It is therefore assumed that Indiana's service system is more affordable for the state than Illinois'. However, Braddock and Hemp show that the opposite is the case. Indiana's 2006 fiscal effort was $4.58, 44% higher than in Illinois. In other words, if Illinois spent at the same rate as Indiana, a state without SODCs, we would have to increase the DD budget by 44%.

The following chart provides more comparisons for 2006:

State	Community Fiscal Effort Rank	Institutional Fiscal Effort Rank	Total Fiscal Effort	Total Fiscal Effort relative to Illinois
Maine	1st	41st	$8.00	+152%
Rhode Island	2nd	45th	$7.15	+126%
Minnesota	4th	36th	$6.91	+118%
Washington DC	6th	46th	$6.14	+94%
Vermont	8th	51st	$5.72	+80%
New Mexico	9th	50th	$5.67	+79%
Indiana	24th	31st	$4.41	+44%
Illinois	43rd	9th	$3.17	100%

The fact is, as Braddock and Hemp also shows, if you combine institutional and HCBS spending, Illinois ranks near the bottom (40th) in fiscal effort for DD services. That is why we cannot find the answer for HCBS funding in the closure of SODCs.

Thank you for your attention to these comments.

Sincerely,

Anne Irving
Policy Director, AFSCME Council 31
Commissioner, HSC

cc: Ashley Rook, Office of the Governor